SANDY HOOK ADVISORY COMMISSION

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Legislative Office Building

Hartford, CT

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RON CHIVINSKI
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AGENDA

I. Call to Order

II. Gary Steck – CEO Wellmore Behavioral Health & Chairman of the Board, Connecticut Community Providers Association

Robert Plant, Ph.D. – Chief Clinical Officer, Wellmore Behavioral Health

Sheila Amdur, MSW – Past Interim President/CEO, CT Community Providers Association

III. Abby Anderson, M.A. – CT Juvenile Justice Alliance, Executive Director; Keep The Promise Coalition Children's Committee Co-Chair

(Proceedings commenced)

UNIDENTIFIED SPEAKER: We'd like to start our morning. We'll be joined shortly by our Chair, Scott Jackson. We have a full program today, and this would be a good opportunity for everyone in the room on the Commission to introduce themselves, perhaps starting with Denis.

DENIS McCARTHY: Denis McCarthy.

BERNIE SULLIVAN: Bernie Sullivan, former police chief, City of Hartford, former Commissioner of Public Safety for the State of Connecticut, and former Chief of Staff of the Speaker of the House, and lovely retired three times.

ADDRIENNE BENTMAN: Addrienne Bentman, psychiatrist, Program Director at the Institute of Living.

CHRISTOPHER LYDDY: Good morning. I'm Christopher Lyddy. I am the former State Representative for the Town of Newtown. I'm also a licensed clinical social worker here in the State of Connecticut, and I'm a Program Manager at Advanced Trauma Solutions in Farmington.

DAVID SCHONFELD: I'm David Schonfeld. I'm a developmental behavioral pediatrician. I direct the

National Center for School Crisis and Bereavement at Saint Christopher's Hospital for Children in Philadelphia.

HAROLD SCHWARTZ: I'm Harold Schwartz. I am a psychiatrist and Chief at the Institute of Living and Vice President of Behavioral Health at Hartford Hospital.

KATHLEEN FLAHERTY: Kathy Flaherty, staff attorney at Statewide Legal Services and a mental health advocate.

ALICE FORRESTER: Alice Forrester, Executive Director at Clifford Beers Clinic in New Haven.

BARBARA O'CONNOR: Barbara O'Connor, the Chief of Police at the University of Connecticut.

ROBERT DUCIBELLA: I'm Bob Ducibella, founding principal and Principal Ameritas, Ducibella, Venter & Santore Security Consulting Engineerings.

RON CHIVINSKI: Ron Chivinski, teacher, Newtown Middle School.

PATRICIA KEANEY-MARUCA: Pat Keaney, member of the Connecticut State Board of Education.

SHEILA AMDUR: Sheila Amdur. I'm the outgoing interim CEO at the Connecticut Community Providers Association, and I'd also just like to introduce Morna Murray, who is our new president and CEO, and thank you

very much for having us today.

ROBERT PLANT: I am Dr. Bert Plant. I'm the Chief Clinical Officer at Wellmore Behavioral Health.

GARY STECK: I am Gary Steck. I'm the CEO at Wellmore Behavioral Health, and I'm the Chairman of the Board of Connecticut Community Provider Association.

SCOTT JACKSON: And I'm Scott Jackson, Mayor of the Town of Hamden. We want to thank you all for coming in today. So, why don't we get into the first panel, which is addressing the behavioral health needs of children and youth. So, friends, the floor is yours.

GARY STECK: Thank you, Mayor Jackson, and members of the Commission for this opportunity to speak today. We have already introduced ourselves, so we can skip over that.

CCPA is a trade association that represents organizations providing services and support to people with disabilities and significant challenges including children and adults with substance abuse disorders, mental illness, developmental and physical disabilities. CCPA provides service to over half a million Connecticut residents a year.

Dr. Plant and I were among 23 Wellmore staff who were early and first responders to the shooting at

Sandy Hook Elementary School. We were blessed to be joined by our state agency partners and dozens of colleagues from CCPA members such as Family & Children's Aid, Clifford Beers, including Dr. Forrester, Wheeler Clinic and Yale on site during those first critical days.

Now, sometimes it's in our darkest hours that we find our greatest strengths. We come before you today to offer some concrete action steps and recommendations that we believe offer the hope for a better future for Connecticut citizens struggling with mental health problems. But before beginning our presentation, we want all those watching and listening in Newtown and throughout Connecticut to know that we remain ready and able to help today. We know there remain many folks who have put off getting support, assistance and counseling because they wanted to make sure that others got help first. We also know for others who felt they could manage on their own, that the burden remains heavy. We urge those in need to seek counseling. For most people, counseling offers relief that can help you feel at least a little better. The best way to get this help is to dial 211. You will be connected with confidential and discrete services near your home, so please call today.

I would just offer a basic overview before we get into this, and I will sort of do an executive summary.

Mental health problems are common, and Dr. Plant is going to get into some detail about this, but in the United States alone, 57 million people each year suffer through mental health issues.

Mental health treatment works. I think there's a lot of misnomers about this, but the success rates for mental health treatment are comparable, or in some cases, better than those of other chronic medical disorders such as diabetes, asthma and heart disease. Only a third of people with mental health problems access care in a timely manner, and there are significant human and economic costs to poor access and to care that is not effective or is not as effective as it could or should be. And just as an example of that, people with severe emotional or mental health issues tend to live much shorter lives than their peers. And we'll talk in detail about that later, also.

So, there are ten things that we believe that we can do now to significantly improve the system and the outcomes that it produces. The first is restore the funding for the proposed cuts of $63 million in mental health and substance abuse treatment funding from the Governor's proposed budget. This is a time of

unprecedented demand for our services. We really need to be all working together on this. It's sort of counterintuitive, but we hope that we can overcome this hurdle so that we can keep the system intact and supportive of all those in need; established rates or other payment mechanisms and Medicaid that cover the full cost for delivering care; assure the Mental Health Parity Act is enforced; support U.S. Bill 2257, Excellence in Mental Health Act; support the delivery of excellent care through the promotion of evidence-based practices; initiate a wide-scale public information campaign to increase knowledge and understanding about mental health issues and reduce stigma; improve coordination across systems and programs; expand prevention and early intervention; strengthen existing crisis services; and expand funding for school-based services and behavioral health care.

ROBERT PLANT: So, just to say a little bit more about how common, unfortunately, mental health problems are, the most recent data indicates that approximately 50 percent of adults at some point in their life will meet criteria for a mental health disorder. We also know that for most of those adults that have a mental health disorder at some point in their life, that disorder began in childhood, typically before age 14.

We also know the World Health Organization has been computing something called the Global Burden of Disease, and it's really a way of looking across the world at what diseases are creating the greatest burden to individuals and societies. And they have identified those that lead to the highest rates of disability and human suffering. And they have their top ten diseases that contribute to this burden across the world, and five of those top ten are mental health disorders. They are listed here as depression, alcoholism, self-inflicted injury, schizophrenia and bipolar disorder. So, those are five of the top ten across the world, and you see the same thing in the United States.

We also know that for children, one in five, roughly 20 to 21 percent of children, have -- meet criteria for a mental health disorder. And for a subgroup of about half of those, their disorder leads to very significant impairment and their ability in school, at home, in the community. And so what we have is a pretty big problem, a very common problem that requires a great deal of attention.

So, fortunately, we also know that there are many mental health treatments that work, and that treatment is effective. A survey by the American Psychological

Association showed that nine out of ten individuals who received psychotherapy found that it was helpful. We know that effective medication therapies exist for most but not all of the significant illnesses that -- mental illnesses that individuals suffer with. And when we have done meta-analyses, which are basically taking large numbers of studies that have shown to be of high scientific value, we take those studies and we put them together and we look at what is the overall pattern of all of these studies showing us; that there are very strong positive effects for psychotherapy on symptoms and on functioning, and that those outcomes are comparable, in most cases, to what we see for medication therapy. In some cases, the psychotherapy produces a stronger effect size than medications. But it's not really looking to pit medication versus therapy because the general consensus is that when you do both together when someone is depressed, gets both therapy and antidepressant medication, that that's when you get the best outcomes possible.

One of the things I will say, though, is that not all treatments are created equal and that we don't see uniform effects or uniform outcomes across any therapy that is delivered. And there have been thousands of studies over the last 10 to 15 years that have shown

that what we call evidence-based treatments, and those are treatments that are very well defined. They are researched to show their effectiveness. They are compared to other types of treatment and to what's usual care or usual care that is delivered out in the community. And there's a very strong set of findings that show that typically these evidence-based practice, where there's a lot of attention made to how do you deliver this service, how do you make sure that it's consistently delivered in the same way each time it's delivered, that they get better results than usual care.

And so, there's been a growing movement in mental health to try to make more of the services that are provided evidence-based. You see the same thing in medicine and in education and in other fields as well, trying to use what the evidence shows works to get the best outcomes. Despite this, though, and despite our knowledge of some treatments that work better than others -- there was just a recent article in the New York Times, March 25th, that reported -- they did a survey of therapists and found that very few, less than 25 percent, indicated that they were delivering some kind of evidence-based treatment. And then when you look even further at that, even though some therapists

say they may be delivering it, it wasn't clear whether they were actually delivering it effectively or not or whether it was just based on a single training.

And so why is there this gap between what we know works and what is actually being delivered in many cases? There's sometimes a lack of funding because it can cost sometimes more to deliver these evidence-based programs. There aren't many incentives right now because if it's a fee-for-service system and it's an insurance payment, it's going to pay the same for any kind of therapy as it is for an evidence-based treatment. Our training programs and higher education, I don't believe -- haven't caught up with this trend and aren't adequately preparing folks who are graduating with degrees to deliver therapy with an understanding of these evidence-based treatments. And there, also, tends to be a lack of awareness amongst people in general, including consumers, so that they don't know what to ask for.

The issue that Gary mentioned before is that even though mental health problems are very common, there's really only about a third of the folks who have the disorders who actually get care particularly in a timely manner. And there are many different barriers, and my colleague Sheila will go into a bit more in

detail, but some of them are the stigma, the shame and the blame associated with mental illness that keep people from seeking care.

The capacity of the system and the rates that get paid, sometimes it can be a confusing system, depending on how old you are and what kind of diagnosis you have, where you get care. So, the system itself can create a barrier, the general knowledge of the community, and that there can sometimes be limited range of treatment options so that maybe somebody needs more than outpatient therapy but they don't need to go into the hospital but maybe that's not readily accessible because of their insurance plan or something else. And it can be difficult, particularly within private insurance, to find a qualified provider easily who takes your insurance, who's available to take new patients and who can be -- you know, provide convenient hours.

SHEILA AMDUR: So, you know, what we're trying to do in this presentation for many of you, perhaps, who work in the field, you know these things, but the reality is, I think, to understand the prevalence of mental illness and its impact upon our health as a society, to understand -- to have some basic understanding of what these are, these are

biologically-based illnesses, whether in a child or an adult, and to understand what the issues then present in terms of why people can't access care, I think, is very important to be able to change what we currently have today, which is a fairly broken system.

I've worked in this field all of my adult life. I have experienced in my own family serious mental illnesses, and I'm very much aware of the fact that stigma -- stigma is the overwhelming issue to people seeking access. The Surgeon General highlighted this in his 1999 groundbreaking report, and even though it's a report that's -- how many years ago was that, 14? -- 14 years ago, it's still an extraordinarily important report. Today, even though I think the public understands much more so than ever that these are biologically-based illnesses, the public's view of mental health and what we internalize in our own belief system is much more negative than it ever was. We're going to stress -- I mean, some of the outcomes where, you know, we've talked about failure to seek -- access care for -- and I know we're supposed to be talking about children, but -- we are going to talk about children, but many of the -- many of the serious problems that exhibit themselves in childhood become then exacerbated in adolescence, and a lot of the

long-term research that is going on shows that you can maybe turn some of that around. And when it isn't turned around, so going into young adulthood and adulthood, really impairing the capacity of the person to be a productive citizen.

I strongly believe -- and I don't think it's just my belief, I think it's a fact -- that because of the stigma related to mental illness, the treatment of mental illness has always been a second class in our health care system, and that gets reflected in the rates for mental health. Some of you -- you know, I won't -- I know it has to be proven, so it may not all be true, but there's a lawsuit against a major insurance company in our state about a -- Connecticut and the American Psychiatric Society related to the rates they pay that they say are differential related to mental health treatment.

We have very, very low rates of payment in this state of Medicaid that pays for poorer populations. In fact, Connecticut has one of the worst records in this country to recognize the costs of what it costs to provide care in terms of what state government does, in terms of contracting with private non-profits.

Psychiatry -- if you look at the rate -- we should have actually provided you with that -- if you look at

the rate of increase in spending in health care, the rate of increase in spending for mental health treatment is far lower than -- far lower than it is for general health care. And this has led to, I think, a shortage of psychiatrists because psychiatrists, in terms of reimbursement, are not paid as well. The demands are extraordinary on psychiatrists wherever they practice, and obviously, our capacity has not kept up with demand.

ROBERT PLANT: One of the things that I had mentioned earlier as something that interferes with accessing care is that we have a very complicated system of providing mental health services. In the President's New Freedom Commission, which was about seven years old, I think, for too many Americans with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. And so what we have are many different provider systems. We have many different state agencies. We have private insurance. We have Medicaid. We have different criteria. And as a result, trying to navigate that when you have a problem is a significant barrier to receiving care. So, we have -- you know, in Connecticut we have DMHAS, the Department of Children &

Families, the Department of Correction, the Court Support Services Division and the Juvenile Branch, Judicial Branch that provides some services. The Department of Public Health has a role in overseeing things. The Department of Developmental Services offers services for a particular subgroup, and they all fund these different components, but if you're a family or an individual, it can be really daunting to figure out where do I go, which door do I enter. And they all have their own criteria, eligibility criteria, means of access, exclusions, et cetera.

And so this slide is really just to be illustrative. It's something that I put together. I don't know if I can vouch for the percentages, but it really shows you -- it's meant to show how complicated things are with the Department of Public Health, Department of Developmental Services, CSSD, D.C.F, the Value Options Plan that oversees Medicaid, and other services funded through DSS. It's really very complicated, and the degree of overlap is significant. Similarly, if you look at who are the provider groups, who's providing services for children and youth, you have some D.C.F. funded grant programs. Some of them also receive funding for Medicaid. You have federally qualified health centers. Lots of services are

provided in schools and school-based health centers and other grant funded care. There's pediatric care that provides some degree of mental health service, private group practices, et cetera. So, you have this really patchwork type of thing, which in some ways offers lots of options, but mainly what it does, at times, is create little bits of care being provided here and there and often not coordinated in a way that is in the best interests of the child, the family or the adult.

GARY STECK: I think this Commission has already heard a little bit about Mental Health First Aid, and there are other models that are being proposed and suggested as means of improving the knowledge and understanding in the public and amongst professionals related to mental health issues. But one of the things that I think has been most striking for me in particular over the last four months is, I think, there's a general misunderstanding that everyone who is a nurse or physician or who is medically trained is trained in understanding mental health issues and is comfortable in dealing with the topic. And I have witnessed that in the way in which there was -- obviously, right after the shooting, a tremendous need for people to rush in and to provide support. And then in the days and weeks after, families and all those

affected reached out to their health care providers, and their -- other people in the community that they felt supportive of; only some of whom felt comfortable and ready to provide support or even felt that they had the information necessary to provide the support.

And then certainly, this is a broad circle, but we think, as our field, the stigma associated with mental health and substance abuse issues is such that we're just getting our voice. There are many people that are uncomfortable with the topic. There are many people that are uncomfortable with the intensity of it, but we feel it's imperative that in the context of our longer-term solutions for Connecticut that we begin looking at how we can change public understanding of this so that we identify and connect with people as soon as possible and then make the bridge in connection into care quick, seemless, and supportive.

Dr. Plant and I both have been treaters for many, many years, and one of the most frustrating things that we experience is when someone comes to us after having a bad experience someplace else. So, we want to make the entry points into the system supportive. We want to make it comfortable for people to seek aid quickly, and we want to develop ways in which we identify these issues earlier before small things become bigger

things.

In the context of what can be done, there are -- and referencing Dr. Plant's two slides -- very, very complex system. Who is the payer for care matters a lot in terms of what care ends up being delivered. So, in Connecticut, it actually turns out that the Medicaid system has a quite robust menu, although the reimbursement and payment structure is such that few private providers choose to participate in Medicaid. It has many services that are simply not available to taxpayers, including home-based services, intensive services, early childhood services and case management.

So, there are pieces of the Medicaid system that we feel offer great hope for the future of an improved system, and yet the funding mechanism that underlies it is a disincentive for private providers or any kind of providers to provide more care or to participate.

Equally, on the commercial insurance end, there are many types of interventions that are now showing to be sort of state of the art and cutting edge like peer specialists, peer coaching, supportive housing and recovery housing for persons with mental illness or who are in recovery from substance abuse that are simply not reimbursed under commercial insurance, but they either maybe partially reimbursed under Medicaid, or

more likely, the state grant system provides some of those services, but they are disconnected. So, we think that there are pieces that are there that offer hope, but it's very disconnected.

Finding a provider. In mental health and substance abuse services, our human time is -- and our labor costs are labor intensive because the unit of time is at least an hour. So, you may go to see your general practitioner who might see three or four or five people in an hour, maybe less, but in our field, the typical intervention is at least an hour of time. So, if you are running a private practice and you're running a solo practice, if you see 40 people in a week, that means that it's 40 hours plus all of the paperwork and all of phone calls and all of those other kinds of things. So, it is not easy to find someone who is in your network. It is not easy to find someone that's open. It is not easy to find someone that has your specific expertise. If you're a family, it's very difficult to find someone that will provide availability for after hours, after-school hours treatment, so that your child does not have to be removed from school.

At Wellmore, we run a very large child and adolescent, and for that matter, adult practice. The

call for our services is so substantial that many of them do happen during the day, and there are -- we've even had difficulties with school systems that discouraged kids from coming for appointments during the day because they didn't want them to miss school time, and yet their emotional and behavioral problems were such that they were gravely suffering at school.

So, it sort of is a complex system, but Connecticut does have a deep pool of quite talented people. My experience in the days and hours after the tragedy in Sandy hook was it was very difficult for us to identify people that had the specific skills that we were looking for that Dr. Plant and I and others who had families that we needed to connect with for care to find people that were skilled and trained in evidence-based approaches or experience working with traumatic grief that happened to also be available that have after hours -- I mean, have hours in the afternoons and those kinds of things, that they all aligned. So, it's a -- the potential is there, but the system is also quite stressed.

ROBERT PLANT: So, in speaking about these various barriers and access difficulties, one of the things we need to recognize is how costly it is when people don't get the care that they need. In 2010, suicide was the

10th leading cause of death in the United States; over 38,000 lives. And, presently, I'm sure folks have heard that for active duty veterans, more are dying from suicide than from being in combat. It's estimated that roughly a quarter of the nation's work force experiences a mental health or substance abuse disorder, and that depression alone contributes to 200 million lost workdays each year.

And when you look at the financial burden of mental illness, it's not chiefly the cost of the treatment that creates that cost burden, it's all of the other related things that end up occurring particularly when someone is not treated. So, those include things like unemployment, absenteeism, drop out from school, poor school performance, disability, et cetera. It's those costs that are the great burden as well as the obvious human suffering that goes along with it. So, it's very costly that we don't have a good system to get people matched up to the treatments they need.

SHEILA AMDUR: So, you know, as we said at the beginning, and now I think we'll go into a little bit more depth, and I think with lots of time for your discussion and questions, are several action items. And, really, they focus, as we've been trying to focus,

on promoting understanding and acceptance of mental illness so people don't feel any hesitation in seeking treatment for themself or a loved one, assuring that we have access and we have a rapid response, that we have early intervention and that we have a coordination of care across systems. I think all of these recommendations come into that picture.

The first -- frankly, and I think we have to stress that over and over again, restore funding for the -- the $63 million in the Governor's budget that relates to funding for clinical services that are Medicaid reimbursable in the next two fiscal years. We understand why that happened. There was an assumption because with the expansion under health care reform, the Affordable Care Act, that somehow these -- this would all be paid for. And let's remember the expansion is 100 percent paid for by the Federal Government. The reality is that because the rate -- rates are so low, Medicaid rates are so low, we're looking -- we're doing a cost study right now that basically covers at a maximum 50 percent of the costs providing outpatient care, detox treatment and so on. So, this is going to result in severely, severely reduced access. So, we are also promoting a rate commission or rate study that, actually, in the state

looks at what are the cost, what are reasonable costs for delivering care.

Mental Health Parity. We have legislation that is pending but enforcing the Mental Health Parity Act. Parity basically means it was a federal law requirement that -- parity simply means that you treat mental illness as -- and pay for it in the same way that you would treat for any other -- any other health care condition, and it still isn't happening.

There's a federal bill, Excellence in Mental Health Act that's interesting to me, having worked in this field so long. This is the 50th anniversary of the passage of the first comprehensive community mental health legislation under President Kennedy. And this Excellence in Mental Health Act essentially caries that into today's world.

We have said promotion of evidence-based practices. I can't stress enough a wide-scale public information campaign. We're not talking about a lot of money here. You know, this is something that the state could partner with the Ad Council, with foundations, with others. They've done this in Sweden. It's something we really, really, I think, have to consider. It's a basic public health issue, coordination of care, prevention and early intervention.

Let me just note that for the 16 to 25 year-olds, this is a population of young people who are at the highest risk for early onset of mental illness, of suicide prevalence and of substance abuse -- heightened substance abuse problems. Existing crisis services we'll go into more and funding for school-based health service and behavioral health care.

I talked a little bit about what is happening with the budget, and we -- the Governor's budget also assumes that everybody will be enrolled as of January 1st, 2014. We know, and I think our own state officials have said there will be a -- people will sign up gradually over time. We have many services that are provided clinically that aren't supported. And so we have to look into the future. It's always, you know, the laws of unintended consequences. If you do something, what happens that you did not expect will happen? And the access, we are very concerned, is going to be severely limited. And we know because our providers are already making plans to shut down and sharply curtailing their services as a result of these cuts.

I'm not going to repeat what everybody told you on the next line. We -- one of the areas that concerns me the most -- it's the most expensive area in terms of

what is done in outpatient services is medication management for people who have the most serious illnesses, and that includes children. And there's no way -- I mean, rates just do not -- even the grants do not cover -- the grants that providers receive do not cover these costs.

Let me just mention that Connecticut has been a very heavily grant-dependent state for its clinical treatment of people who are on Medicaid, much more so than other states in the country. Frankly, the reason for this, since I've worked here -- worked in this field maybe too long at this point -- is that we -- this was really a delivered policy decision. It's a way that you limit access. Medicaid is an entitlement. If the child or a family or an adult presents for treatment with a medically necessary condition under Medicaid, they must be treated. If you present and, you know, you don't have the capacity to treat, I guess then they have to wait, but by -- grants are a fixed amount. Grants don't expand as the way Medicaid treatment -- as the way Medicaid fees expand. So, over the years, we have used grants. And now, paradoxically, we're cutting the grants without looking at what the outcome will be.

Okay, yes. I'm continuing. So, parity. We've

talked about that, talked about that. The other interesting thing about parity is that it doesn't apply to Medicaid. So, that's the federally -- the federal health insurance program that all states provide, it doesn't apply to Medicaid. You don't have to treat -- you don't have to treat health care services equally under Medicaid under the national parity law. And Connecticut could remedy that, but at this point, it does not, and it's probably one of the reasons why behavioral health rates are as low as they are.

We have a -- as I had noted, there is a law currently in the Legislature related to parity. Just the national -- the national -- the national law, I think, is of importance. I guess we can individually support that. I think our state delegation in Congress is supporting it, but it would basically allow a payment system, which is what this all about. It should be about payment and performance, quite frankly. You know, your payment, as hospitals are learning, are more and more linked to performance, and they should be for other services, but it would have a payment system that basically would begin to pay at a rate that reflected the costs of care based upon the actual ability of a behavioral health center to provide outcome based care.

ROBERT PLANT: So, another area where we think is critically important, I spoke earlier about the gap of -- between what we know in science and in our research and our experience of what are the most effective treatments, and yet, they are not routinely delivered or not easily available, and it has to do with a number of things.

One of the ways -- in my previous work when I was with the State of Connecticut that we were able, through D.C.F., to expand the number of evidence-based practices that were available is to pay for those components of the treatment through a grant funding structure that wouldn't be reimbursed under Medicaid. So, for example, if you're delivering something like trauma focused cognitive behavioral therapy, that's a very effective, very well researched treatment for children and adolescents who have experienced trauma. There are many costs associated with it beyond just simply being there with the family and with the child and doing the therapy. You need to have specialized training that occurs. If you're going to deliver it effectively, there should be ongoing consultation to those people who are delivering the service to make sure that they're delivering it appropriately. You need to have measures and a quality assurance system to

see if you're on track with the delivery of that care. And all of those things cost money that Medicaid doesn't cover.

So, one option is to look to expanding that strategy of providing grant funding to community providers that will help them to deliver specific evidence-based treatments that will serve the greatest number of children and adults in the state.

There is also an option to provide enhanced rates because right now if I deliver an evidence-based treatment or I deliver just usual care, there's no differential rate that is paid. And one of the ways that would increase decimation of evidence-based care is if there were differential rates made based on delivering an evidence-based practice.

We do need to look at promoting, as I said earlier, within the educational system, that folks coming out of graduate school actually get trained in these approaches or at least get exposed to them, which is not on a wide-scale basis happening right now. And I don't know that we have time to get into it today, but there are sometimes systemic barriers that get in the way of evidence-based practices being delivered, and those would need to be addressed as well.

SHEILA AMDUR: So, let me talk little bit about a

public health campaign. You know, I'm a mental health professional. I've worked my life in this field, but I've also had the privilege of working very closely with the National Alliance on Mental Illness that I think the Connecticut chapter presented to you, also with a Keep The Promise Campaign that is a coalition that is going to be presenting to you later; a coalition of consumers and families and professionals. And it is profound to me when working, really, as a volunteer with families or individuals, the shame and the blame. The shame, first of all, about the illness, feeling that it's based upon some personal fault or failing or what did I do wrong as a family member or the finger pointing by others of us when we see something happen, and the impediment that that then -- that that then interjects in anybody trying to seek help, frankly, because of -- because of the way they believe they're going to be viewed and treated.

So, Mental Health First Aid is part of that, but I think it has to go beyond that. I mean, it has to be on the sides of buses. It has to be in public information. It has to be in famous individuals who themselves have had this experience or in their family coming out and talking with us. And you do this by, I think, having leadership and enlisting, as I said

earlier, people with -- people in the private sector to work with you. It's so that -- it's so that if you call -- Gary said at the beginning, you know, 211. 211 is really aimed at anybody with a child -- any family who has a child in crisis, you call 211 and you can get immediately hooked up to care. But how many of you who aren't in the system even know about 211? I mean, 211 should be a universal number that we -- is familiar to all of us as 911. And when you call that number, you should be able, just as you would in a medical crisis, another medical crisis, to get connected immediately, to have somebody on the other end of that line who is very knowledgeable, and there's funding to support that kind of care management that makes sure the person is hooked up -- that you then get hooked up and there is accessible care because, frankly, if we do a public health campaign and we don't have accessible care, I don't know -- the outcome would not be exactly, I think, what we hoped it would be.

ROBERT PLANT: And so another improvement is in the area of prevention and early intervention. We know when we look at the numbers of mental health professionals and the numbers of individuals who have mental health problems, we're really short in terms of the work force, and that really one of the most

important ways to address this is to have early intervention and prevention so that less children are growing up with a mental health problem. One method of doing this is to build into our schools through teacher preparation and certification using evidence-based approaches that teach about social and emotional learning because we know that social and emotional learning are just as important and just as key as the other types of learning that takes place in school. And, often times, if children don't have the social and emotional skills to navigate in the classroom, they are unable to benefit from other instruction or don't benefit as much as they could.

There are also other types of early intervention programs, Birth to Three Programs, Child First that really take a look at children who may be at risk due to poverty, due to exposure -- you know, there's -- to neglect or abuse, specific programs that look at children, young children, at risk and how to address those risks so that they don't develop into a disorder.

Another area is with adolescents because we know that for major disorders such as schizophrenia or bipolar disorder, they usually first appear in adolescence or early adulthood. And there's a lot of evidence coming out to indicate that if you intervene

quickly and effectively with a combination of, you know, family education, psychoeducation and medication, that you can really reduce the impact of that potentially very significant disease if you go right at that period where children are starting to show signs of a more major mental illness. And so, I think those are some of the key things in terms of prevention and early intervention that would help to promote better outcomes.

And the other piece that I have had a lot of experience with over the years is in developing crisis services. Sheila was speaking earlier about 211. And about three or four years ago, we entered into a project with 211 to link it to our emergency mobile crisis service for youth and adolescents in the State of Connecticut. And by doing that, we went -- we saw a 300 percent increase in calls in about a three-year period, which was really one of our goals to have better utilization and access to this program. But what we know is that when families, children, adults are in crisis, it's often one of the unique opportunities to engage into treatment because there's high motivation, and you have a situation around which to rally and to try to provide assistance. And so having a crisis service that is readily available and

can help both stabilize the crisis but also transition that child or adult to ongoing services is a critical piece of the system.

Now, both DMHAS and D.C.F. operate crisis services. On the D.C.F. side, I think the thing that they've been running into is they're sort of reaching the max of what can be handled in terms of the volume because there's been this 300 percent increase in calls over the last number of years. And so, you know, additional funds need to support that program so that it can be more available, and also to do -- you know, it sounds like even though we've had a 300 percent increase, I think if you asked most people, you know, what would you do if your child was in crisis, it's still take them to the emergency room or call 911 because not enough people are aware. And so there would be need to be some funds put into some kind of awareness campaign. And I think on the adult side with the DMHAS services, they still serve a relatively narrow target population that can access those services, and our belief is it should be the same as it is on the children's side where any individual with a psychiatric and emotional crisis could contact that and get a home-based immediate response.

Another area that we know is a very, very

effective way of delivering care and to provide early intervention and prevention services is in the school. Children spend many, many, many hours in school every week, every year, and, you know, one of the ways to remove the barrier of access is to provide the services right there where the kids are at. And so we also know that in Connecticut we have a school-based health center program. It doesn't reach all schools. It reaches some schools. The model combines physical medicine care along with mental health care. And what we find is often times kids are going to the office for a stomach ache or a headache or some other vague physical concern, and what we find out through that intervention is that it's really an emotional, psychological, it's a depression or it's an anxiety, and then they can be served within that without stigma because they're going to the nurse's office or to the -- and they don't get identified in a way that creates a barrier. So, I certainly think that school-based health is an excellent way to deliver this kind of care, but we need more of them. It's really spotty in terms of where they are around the country -- or around the state.

But also one thing that I've seen through some pilot projects that has been very effective is we don't

have enough psychiatrists to treat children in the schools, and there can be a lot of missed appointments when they have to leave school and then go to an office. And there have been some very successful projects with telepsychiatry where the psychiatrist is in their office, the child is at school, and they're linked together through video conferencing and they can have a visit in that way. And there's some very good outcomes associated with that.

So, just to kind of sum up -- I know we've presented a lot of information, ten different kinds of recommendations or action steps that we think would be helpful in improving the outcomes for kids, families and adults. We know what works. There's very clear kind of emerging evidence about what's most effective and what's going to produce the best outcomes that will reduce pain and suffering, improve efficiency and effectiveness because if we're really providing the most excellent care possible, fewer children are going to drop out of that care or not get better or not need to move on to more higher levels of care and they'll stay more engaged in treatment and get better outcomes.

We believe that many of these things, because so many costs get shifted in other arenas, whether it's into the judicial system or into the school system or

into other places where we end up paying for it through other remedial services or, you know, through crime, through many other ways, and that this would be cost neutral or save money if we were just more effective and had a more organized system as we have described. And that doing nothing is really going to end up being more costly both in human terms as well as financial terms.

So, that's the end of our presentation, and we'd be very interested in hearing what questions, comments, et cetera that folks have. I know there's a lot.

SCOTT JACKSON: Thank you for your presentation. Questions for the Panel? We'll start with Mr. Sullivan.

BERNIE SULLIVAN: We know that we do annual physical exams now. Insurance companies like to pay for them because they know early identification produces less cost to intervention. Has any thought been given to developing, maybe just within the school system, where there was a periodic mental health wellness exam given because a lot of these illnesses do start at that age where you would do one maybe in grammar school, maybe one in high school or junior high, whatever, as the same means of trying to identify things earlier enough where you can get a cheaper,

early intervention which might encourage insurance companies to participate more?

GARY STECK: There has been some work done in Connecticut on this. The project that we're most familiar with in Waterbury, we -- there's several pediatric practices that do universal screening at all of the pediatric visits because it's a very normative, neutral setting. The kids come in on a regular basis. They have a caregiver with them, and there's a normed researched tool that is used, and then, basically, if there are issues to be followed up with, we have a relationship with several of these providers, and they directly connect them with us. In the context of schools, it's somewhat of a controversial topic because there's some concern about the potential of identifying and labeling. We think it warrants a public discussion. We certainly believe in empowering parents to make decisions for their families and supporting them, but I think that in the context, especially of what we're seeing and how quickly things are changing in our field, this is something that does require more dialogue. There are some schools that we were involved with a small project locally where there was some screening done, and there were -- parents were concerned about it, but we're learning as we go on

that. But it is something that warrants much greater public dialogue.

DAVID SCHONFELD: I understand that your presentation was to give an overview and a foundational representation, so I appreciate that. But moving forward -- so perhaps these are things to consider to get information back to the Commission later on. There, obviously, is a lot that you're suggesting. And when you talk about restoring $63 million in a budget during a time -- at the same time that you're also suggesting a lot of expansions of reimbursement, new programs, other approaches, I think it would be helpful to the Commission to drill down a little bit more to do the really hard work, which is how do you prioritize if there's only $5 million or $10 million or -- and I know we don't have a particular dollar amount, and I'm not suggesting we limit ourselves, but we do need to think about how we would prioritize because if, indeed, the system is -- and I know the system does many excellent things, and I know you weren't suggesting when you say it might be broken, but restoring a broken system is not actually necessarily going to do anything better than what we had before; so, thinking through how to help us with the prioritization, which is a really difficult task. The other is if, indeed, the system is

not ideally set up, and I don't think it is in any state, how are we going to look at innovative models. If we talk about screening, if we say that the prevalence is 25 percent when we've done some screening of large school systems, like New York City school system, we can't really refer 25 percent of the population out. And if the lifetime prevalence is 50 percent, referring them all out for subspecialty treatment is probably not going to be viable. So, we might want to be looking at other innovative models to do more of the prevention work that you referred to, early intervention and other complementary approaches to it. And then the only other thing to -- just as a comment for us to consider is if part of the task of this Commission is to come up with suggestions for Legislative changes and Legislative approaches, many of the things that you're recommending I fully endorse, but I also know don't work well in terms of Legislative solutions. So, trying to change education and training in a professional field is hard to do through Legislative mandates or Legislative approaches. Similarly, trying to prioritize as to what is best mental health treatment, I don't know that you're going to really want the Legislature to dictate for the professional field how to do that. So, I would like

you to think through with us, not necessarily today, but over time what are actually some of the recommendations for specific Legislative actions that could be taken that may create some solutions that will be measurable and impactful with perhaps limited resources.

ROBERT PLANT: I appreciate that feedback, and I kind of think you're right on. I think just off -- you know, based on our thinking on this, the rates are really key because a lot of the things that can be potentially done to improve care to bring in evidence-based practice are tied to whether there's a sufficient rate to pay for the care. And so I think that's a -- that is a priority, particularly as we're moving, presumably, from less grant funded into more of a fee-for-service environment with the health care reform. So, I think there needs to be a lot of attention paid to the rate issue, and that is something that does get discussed legislatively about how rates are set, and so I would say that's a big one. And also within that, we do have some experience in Connecticut of establishing some differential rates for particular programs that meet criteria. There were things written into our Medicaid plan under the rehabilitation option that identified a set of criteria by which certain

programs could be identified for Medicaid reimbursement at a rate that would cover the cost. And there is -- you know, it recently passed, and it's there. It could be acted on. So, I do think there are some specific -- those are two specific things. But I hear what you're saying is particularly legislative proposals, and ones that recognize that we're not going to be after the funds to serve everyone in the community.

DAVID SCHONFELD: If I can just follow up, just to clarify. Certainly, the Commission can make recommendations about the importance of professional education and training, and I'm not -- I'm not, obviously, in the position to limit what we're considering doing within our report, but I just do know from experience that those recommendations are helpful, perhaps, but they're not necessarily as directly impactful. And so, if you could help us, so even when you talk about rates, is it that you want a recommendation that the rate commission you were talking about where that party be empowered to make certain decisions -- you know, if you can, again, help us with some of the specifics. And I'm not suggesting right now, but in follow-up conversations, I think we're probably more likely to be able to make a difference if we know exactly what's going to make the

biggest difference, if you can help us with that.

SHEILA AMDUR: We just presented a plan with the Legislature, which I'm sure we can now present to you.

HAROLD SCHWARTZ: I want to thank you for a thoughtful and well-crafted presentation. Thank you for being here this morning. And there is a lot that we could respond to; one comment and then two questions along the lines of the questions that you just received in terms of asking for more detail. But the comment I just want to share is that I very much agree that rates are an absolutely central issue. And I would further observe that I think the notion that the Medicaid expansion incorporated into the Affordable Care Act would actually dramatically increase access to care is the big hoax of the Affordable Care Act, and that has not received sufficient attention. And it is equally problematic in the Governor's budget because the elimination of so many of our grants from DMHAS and other agencies is predicated on the premise that the additional Medicaid reimbursement flowing into the coffers of providers could possibly compensate for those grants when it cannot. And as a provider, I can confirm that certainly the primary alternative to what's what coming down the road is looking at downsizing and closing many of the programs that have

been grant supported in the past because they simply, you know, won't be sustainable. So, very important issue.

Two areas in which I would also hope that you could come back to us and perhaps help us think out in more detail how to proceed, you demonstrated -- your slide on the crazy quilt of agencies with responsibility for various aspects of the supposed system of care was, you know, really illustrative, I think appropriately illustrative, of the situation. Do you have some thoughts about how to undo that crazy quilt into a unified approach, at least on the public side to management and accountability for behavioral health services? If you do, you know, we would love to see it. In the past, pieces of that crazy quilt have at least come up for discussion. The notion that D.C.F.'s behavioral health responsibilities perhaps should be incorporated into DMHAS, you know, et cetera. I'm not necessarily advocating that, just suggesting that's been one example that's come up in the past. This is a very big part of the problem, and we would love to hear your further thoughts about that. Again, not necessarily here, although if you have them here, that would be fine.

My second point that I would like to know more of

your thoughts about has to do with the distinction between the commercial and private side of this issue and the public side. So, you have suggested promoting private insurance coverage of community-based crisis services as an example. You have also suggested that through parity or otherwise, private insurers ought to be funding additional levels of care that they do not fund and recovery-oriented services, which they clearly do not fund. My question is, how do we get there? It seems to me that this issue is at the crux of the distinction between the medical necessity model in which private insurers are essentially paying for what we might generally think of as more biologically oriented ways to look at it, or at least more symptom driven ways to look at illness on the one hand, and the more holistic notion of the many aspects of being human and in recovery that compromise -- that comprise mental health and illness.

The public agencies, for all of their problems, get it to a degree and attempt to make connections such as -- the vital connection between having a place to live and symptoms of depression or schizophrenia, and I think they're equally important. The private commercial insurers -- I could say that they don't get it. I'd rather say that they have no incentive to get

it, and it's not immediately apparent. Now, for all of the talk that we need to move in this direction, we possibly can move in this direction, and if you have some thoughts about that, I'd love to hear them.

GARY STECK: Both of us do. So, Bert has been with us at Wellmore for, what, nine months now, eight months, but our -- my agency only merged recently to become Wellmore, and the whole point of the merger was taking a children systems provider and a adult recovery oriented provider and putting them together under the simple idea which was that it need to be our problem in how people access the system and figured out that we needed to be the ones who were figuring out how they would get into this silo or that pathway, because as an outside consumer, it's impossible to read that chart, which -- actually, the chart that Bert developed was equally inspired by our experience of what we saw at Sandy Hook in the first weeks that there was -- there were so many people who rushed to help, and there's so many ways in which people were helping, we were -- even though we were -- you have a long career with the state, and I've been doing this for a long time, there were new people to us that day. It's such a complex -- and there's so many steps that it really hit home for us that a person who is in crisis or is experiencing a

problem with their child is not going to be sitting there with their encyclopedia of Connecticut resources and is not going to be in a position to effectively advocate or navigate the system.

ROBERT PLANT: I think that it's an excellent question, and I think we will be able to come back with you with other things. What I could say right now is, I mean, one of the means, I think, of writing this is a different payment system where, you know, it's not payment on a fee-for-service basis, but it's a case rate covering a population. And I think eventually that's where the Affordable Care Act is intending to go. And I do think what that does is if you're being paid on your performance and you're responsible for a group of individuals, then there are incentives, then, to provide good mental health care because of how closely those outcomes are linked to other costly types of treatments for heart disease or diabetes or other types of things. I think it's only when it's kind of pulled together in that way -- that's what we need to get to eventually. Obviously, those case rates and that system needs to be very carefully designed and planned, but I think that's sort of a systemic solution. The kind of interim solution may be that there is discussion of reimbursing care management as a

reimbursable service so that you have a guide. It's a crazy system still, but you have somebody who's holding your hand who's trained in it and knows the ins and outs and helps to guide you through it. So, those are at least two that I can think of at the moment, and I'm certain there are others.

GARY STECK: And lastly, you know, our comments are -- we are not at all suggesting that this is solely the government's responsibility to fund or to change, that the community providers are -- we're willing to look at ourselves in the same way as, obviously, Doctor, from your own experience looking at your own system, we need to be a part of the solution and we need to be flexible and willing to change.

It's a whole new ball game. There is rapid change in Connecticut. 2014 is a big year, but we are -- community providers need to be and want to be at the table and part of this discussion, and certainly are not looking for the government to fix everything for us or to fund everything without our help or participation. We need to be a part of the solution also.

SCOTT JACKSON: I'm going to jump in with a question of my own. I have far less, I think, exposure to the system than many of the folks around the table.

I understand your discussion of the inputs in order to extend the services. You need to extend the inputs, but you also talk about these evidence-based practices that provide a better model for delivering the services. Can you -- if it's possible in a brief period, can you explain the difference between, sort of, a standard set of service and one of these EBPs? And we also heard from the advocacy community at a previous meeting that the role of peer support is critical. Can you give me your impressions on that statement?

ROBERT PLANT: Sure. So, with regard to the evidence-based practice, we use an example that may be relevant here, which is, you know, if you have a child who has experienced a traumatic event in the community, whether it was related to something that happened in Newtown or in their own community, witnessing violence, victim of violence, whatever it might be, and you get referred to an outpatient clinic, there are 16 clinics -- I believe that's the number currently, 19? It's gone up. That's good. -- 19 clinics in Connecticut that offer trauma-focused cognitive behavioral therapy, which is a particular evidence-based approach to treating children who have been exposed to some type of traumatic event or having

symptoms related to that. And under that, you have clinicians who are specially trained who collect data throughout the delivery of care to track how the child and the parent who is involved are doing. That data gets, you know, sent in, gets looked at and gets reviewed. And there is also consultation on a regular basis to make sure that people stay on track with the delivery of service. Those are like the key elements of an evidence-based practice.

The alternative would be that you go to a clinic where they don't offer TFEBP and you get whoever the next clinician is on the list who's available, and they provide whatever therapy they happen to be trained in or felt most comfortable with during their training and so forth. And, you know, the reality is the usual care will probably help, and there's a lot of evidence that it does help. It's just -- it's not likely to help as much or as quickly as doing a focused evidence-based practice, like trauma focused EBP. So, that's one example. You can probably count 25 others and all kinds of alphabet soup I could throw at you with MST, MDFT and all of these other things, but that's one.

SHEILA AMDUR: Yes, and Mayor Jackson, I think this gets back to the issue of parity. If you think about medical care, the very rapid trend is this trend

towards paying for health outcomes, paying for performance, paying for practices that really do help people recover and improve their health. And there are penalties being applied to hospitals. There are new models related to physician groups. They're doing this mostly now around people's chronic illnesses, but we don't do that kind of thing in the treatment of mental illness, mental health conditions. We -- you know, we pay for an outpatient visit, which is good and that can help, but we don't say, okay, if you have depression, we really want to pay for -- maybe we'll pay a higher rate for cognitive behavioral therapy because that's going to lead to more success and it's going to prevent emergency room use. It's going to prevent hospitalization. So, if it's -- again, bringing the same -- and we don't know as much on mental health, obviously, as -- you know, the research dollars that have gone into the understanding of mental illness are far eclipsed by any other -- by any other research funding that this country spends. And I think, again, related to stigma, even though the impact, the dollar impact, you know, here and World-Wide is huge for, you know, the five major illnesses that you've heard -- you know, commented on earlier.

So, it's a question of -- and I think, frankly,

you know, you hate to say it, but I think money is going to move the argument because whether it's somebody with a heart condition and diabetes, the highest cost person to treat is that person that has a chronic illness and depression and/or substance use problem.

So, our health care system is very expensive, and hopefully, through more enlightment, frankly, of policy makers and people like you and people all around, we can begin to have people say, hey, we should be doing this. We should be pushing evidence-based practices. We should be pushing pay for performance and for healthy outcomes and requiring the people who provide those services to be able to offer what someone needs for the condition for which they're presenting. As I said, we don't know enough about what we need to provide with the conditions with which people present, but hopefully, that will improve, too.

KATHLEEN FLAHERTY: I just want to follow-up a little about -- you had mentioned the use of the recovery support specialist, and, you know, like the Mayor talked about in the previous presentation when we talked about the use of peer support but also in terms of families with the younger children, family advocates, can you talk a little bit about the use of

all those different folks in the system, especially getting -- possibly getting them paid for and reimbursed for, too.

SHEILA AMDUR: Extraordinarily important. If you are a parent for the first time, you know, confronting a youngster who can't focus, they can't -- they're not sitting still in class, their learning is impaired, no indication of any cognitive -- you know, of any intellectual problem, and you -- you go to your pediatrician and you say, you know, maybe your child has ADHD, you know, what does that mean. The best way for you to begin to grapple with this to understand it and to know how to cope is to be able to talk to somebody else who's gone through this. And as I said, just the -- through the work I've done with the National Alliance on Mental Illness, I think it's quite profound. We have some very limited payment for, actually, those kinds of family advocates through grants. It would be interesting to see if in other states they're using -- well, peer support in some states is a Medicaid covered service. It's the same thing for a person who has a mental illness themselves. The peer support and the person who can assist in almost a care management way, helping them get to appointments, being there, available to talk to them

when they're in crisis has a huge, huge effect in helping that person live productively in the community. And we're just beginning, I think, to think about, you know, how do we make this an integral part of what we do in a treatment system.

ALICE FORRESTER: Thank you very much. I am a member of CCPA and on the Child Board, so I think I wanted to say that first, but, you know, Doctor, you have mentioned around our role as the Commission and what the impact of a report would do and sort of raising, you know, what would be the question. And I'm very struck from our very first presentation we had from the fellow who -- the Governor who was on the Columbine Commission, and his talk about the impact of the report that they produced had this idea of going in quicker after the -- you know, once the threat is identified to go into the school, the building, you know, and have a response within minutes as opposed to hours or -- you know, and that communicating that in their commission report, I think, changed practice across the nation.

And so, you know, every time I drive up here from New Haven, I'm always thinking is what the Commission going to do and what's our role in this. And one of the things that has been extraordinarily distressing to

me is that conversations on gun control are less complex than mental health. And I've had some unfortunate response from our intermediate report of people saying, my God, you didn't mention mental health. Where was the mental health? That they misinterpreted that the intermediate report was a mental health report. And so I think that our role and our job here is incredibly important.

And I just want to point out one point that maybe is not being brought out as much which is around stigma and connecting it to the emergency response and the idea of running in faster, if you will, to the building when the threat is identified. One of the things we heard from Marissa Rendazzo from the Secret Service in the last report -- in the last meeting we had is that threat assessment -- and I know there was a lot of discussion around it -- is not pointing fingers and identifying and blaming, but rather a multidisciplinary informed group of people who understand the signs and symptoms of distress and emergency and can pull it apart. And her description was that it was a case management approach. Find the best person who could talk to the child or the youth and address it, address it and try to intervene in that way. And I think that what we're talking about and what we heard today is

that it's really going to take -- it's not complex, and it's not hard to understand that when someone is in distress, they need help. And the help is available. And it's done in a loving and compassionate way. And I think that if this Commission could focus on the social impact -- it is not going to mean mental health workers who are going to fix this problem. It is going to be the school guard. It's going to be the friends. I heard on the way up here that one in ten kids in college commit -- I think consider suicide, and it is their friends who understand and acknowledge the issue related to the kid's distress. So, it's going to be changing people's perceptions and ability to talk about it. And I think that -- I'm sorry. I didn't mean to take a platform here, but I just want to say that it's -- as a community provider, my job to run this child guidance clinic in New Haven is to understand that it's not just to deliver the services, but to create a community of people who are aware of what to do and how to handle it. And so I think we could have an impact as a Commission to really point out and address that it is everyone's responsibility, you know, to have the knowledge of and to understand and to normalize the conversations related to mental health. And I think Dr. Schwartz, your challenge around

Affordable Care Act is quite complex, but I do think there is an opportunity in the holistic view of health in that if they're going to reduce the costs and visits through the ER, it's going to be through a mental health intervention as well as that. So, I think that there's hope. I think that there's opportunity, but I think that our impact has to be very clearly on addressing the stigma.

BARBARA O'CONNOR: I think that's a great segway to my question. Sheila, you mentioned Connecticut was the worst -- and I need to have you repeat that. What is Connecticut the worst at in the country?

SHEILA AMDUR: Not the worst, but we are -- and Bill has these, I live right next to the campus -- very happy. The -- we're not the worst, but we are one of the lowest states in terms of when the state government -- state government, let's say Department of Children & Families or Department of Mental Health and Addiction Services contracts with a non-profit provider to provide -- it might be case management services, whatever it might be, or Department of Mental Health & Disabilities, it might be, you know, residential support or services for people living in group homes, we are one of the worst states. And looking -- looking, basically, what does it cost to provide this

service and what is a reasonable rate, either through Medicaid or through a grant that we pay for the service. This is from an urban institute study, I think of -- I think it was 2010. It was in -- the Governor's non-profit cabinet highlighted this in their report last October. So, it's interesting because, you know, we aren't a poor state, and we -- you know, we do spend a lot on many, many different kinds of services. It's just that we've gotten to a point in our non-profit provider community that it's basically had almost no increase. I think it was a one percent increase in this, last half of one percent increase this year, but there haven't been any increases just to the grant system in five years. And the Medicaid rate system has had a few specific adjustments, but overall practically nothing in 20 years, that we are so far behind in supporting that cost. Now, we shouldn't just throw money. I mean, obviously, you just can't throw money, and that's why we were talking about, you know, a lot of approaches that are targeted, that are paid for performance, that require productivity, that require, you know, people who are providing the services could be -- you know, to be much more focused on health outcomes and the person, et cetera, et cetera. And there are many things -- there are many

examples of that on the physical health care side, but that's the concern.

BARBARA O'CONNOR: Okay. Thanks for clarifying that we're not the worst, but we're not good. So, just to sort of follow up on that, are there states, other states, that you have studied that have grappled with a lot of these issues that have developed best practices that you might point Connecticut to?

ROBERT PLANT: I mean, I don't know if there's a state you can go to and say they do it right. I know what we do find are there are programs that other states have implemented that have been helpful and successful, and then we look to implement those. And so I know there's some discussion. I don't know if funding has been allocated for -- I think it's called the MCPAP Program, Massachusetts Child Psychiatry and Pediatrics, I think that's what it stands for. But that's sort of like a model program where they bring consultation from a psychiatrist and care management from a trained professional to assist pediatricians in serving children with mental health that are in their -- problems that are in their practice. So, that's sort of -- it's a model practice that Connecticut is looking to adopt. And I think it would be a good thing for us to adopt that. I don't know --

you know, once in a while we've had consultants come in on Medicaid and pretty much what they say is that, you know, if you've seen one Medicaid plan, one Medicaid state plan, then you've seen one Medicaid state plan because they all seem to be organized quite differently. And it's often times difficult to take whole system approaches from one state and apply them in another. That's at least been my experience. But there are lots of examples of, sort of, model programs that have proven outcomes and results and costs savings that we could adopt. I know, for instance, you know, we did, over the last ten years, bring in a lot of home-based, evidence-based programs for juveniles who were involved in the juvenile justice system. And as a result of that, there was a recent report that Connecticut achieved the highest in the country of reducing the rate of incarceration for juveniles. And I can really point directly to bringing those home-based, evidence-based programs into Connecticut, disseminating them widely, had a dramatic impact, and, you know, it's recognized nationally. So, you know, we found these things that we know work, that have worked other places, and then we bring them in and we try to bring them to scale, and they are very successful.

SCOTT JACKSON: Thank you, I think we have time

for one more.

ROBERT DUCIBELLA: Thank you very much. You know, Dr. Schwartz and Dr. Schonfeld have -- and others on this Commission have a great deal more importance than I do. I'm more of sort of an organizational specialist. And if you don't mind, let me just tell you the eight points that I walked away with from your presentation and then ask you sort of the $64 question at the end of it, which is a bit of an amalgamation of what others in the Commission have asked you, but there seems to be an extraordinary complexity of systems to the mental health care process. And I very much appreciate the doctor's representation of that terribly graphic and confusing chart with all of the bubbles that overlap that don't allow anybody to walk through that with any degree of confidence. There's underfunding of programs and provider services. There's a lack of capacity in the system. There's simply too few mental health care providers and professionals. There's a stigma of declaring that one is in need of mental health, and so the treatment doesn't reach all of those in need. But perhaps inappropriate, or perhaps very appropriate, a correlation that mental health patients are inherently violent and this enhances the stigma quotient. We

should increase the interventions of potential mental health disease at earlier ages; increase the availability of mental health services in schools, and advance the increased frequency of evidence-based practices within the mental health practice. And I consistently hear from you, from others and from listening to my colleagues who are more knowledgeable about this on the Commission, that in some cases Legislative action is appropriate, and in some cases, modification of the funding system at the federal and the state level is appropriate; in some cases, training programs are appropriate in some; in some cases, enhancing the ability and efficacy of people within the school and what they do.

I mean, there's a broad range of potential modifications that you've suggested. I look at that, you know, as a building and design and structural engineer and architect and realize that, you know, when we create built environments, there are a lot of different people who participate, and a lot of different things that looked at individually and out of context would suggest that nothing should ever be built and be built well, but it happens. And so the question I have is using that as sort of a paradigm, who is ultimately responsible in addressing these issues under

a unified umbrella with an opportunity to actually affect change here in the State of Connecticut?

SHEILA AMDUR: That's a very good question. And the reality is that, I mean, the -- it is -- overall, it's the state. Now, is there one state entity. Because the state, actually, through its Insurance Department -- for example, our insurance department -- I'm speaking of my personal -- my experience over time, does not really do what it should do to enforce parity laws. We had -- we had the strongest parity law, actually, in the nation. And when the federal parity law was passed, we fought very hard to make sure that Connecticut's law would not be undermined. So -- and so the Insurance Department enforces that. We have a Department of Mental Health and Addiction Service which oversees broadly treatment services -- not broadly, narrowly, because they narrowly -- to people with serious mental illnesses, that treatment system, and the Department of Children & Families which oversees the child system. And then in between, you know, you've got specialized services that come -- that the Department of Education supports in school systems. Those school systems, you know, design themselves, what they're going to do. There are certain things they have to do under the law. You have all of the other

bubbles that -- so, it's interesting because the -- a previous Governor this the Governor's Blue Ribbon Commission on Mental Health -- and, you know, it pulled together all those parties and came up with a comprehensive blueprint, and some of it has been implemented. Most of it hasn't.

So, what does the state do about it? I don't believe, frankly, that a mega agency works. I think it's so big that, you know, nobody knows who's doing what, but there are ways -- the state is, for example, just been funded by the Federal Government -- we didn't even mention this -- but to undertake a look at all of the payment systems in both Medicaid and in private insurance and to design payment models that have more of a relationship to the kind of outcomes that you want to seek. Vicki Veltri, the state's office -- the health care advocate, has been asked to lead that initiative and that's going to be a very intensive six-month process. You know, so there are ways under that that we can -- and that's part of our -- the four-point plan that Dr. Schonfeld, you know, will share that with you that we gave to the Legislature. We said that that -- you know, that needs to include great focus on mental health payment mechanisms. So, I don't know. I don't know that we have any

recommendation that says there should be a commission or a coordinating body. There's a lot of coordination between Department of Mental Health and Addiction Services and Children & Families around young adults, young people, who are transitioning out of the care and protection of the Department of Children & Families, but they don't cover that broader sector of young people whose parents are -- you know, they are not in that system and that are confronted with what happens, you know. When my youngster -- my 18 year-old is suddenly holding himself up in his room and he's acting strangely and screens are falling and he won't see anybody, they don't cover -- you know, they don't cover his problem. So, I don't know. And I think it's a very good question and it -- maybe it's addressed by -- I'm just thinking, you know, extemporaneously here, but maybe it's addressed by having some very focused initiative. I know that the Legislature is -- I think they did pass in their legislation a very focused initiative related to the mental health system across the board, particularly related to the 16 to 25 year-old age group. And so how that's going to be constituted, what they're going to do with it, I don't know.

ROBERT DUCIBELLA: Thank you, because the note --

the question I was going to ask you is, if we have a system that isn't working particularly well, because you have documented the fact that it's not, and if it's -- if we're not in a clear position to say we have a Navy that consists of a wide range of boats that -- all of which need to be addressed and we don't really have an admiral, it sort of seems to me that one of the things that I will propose or the Commission will certainly look at, if it makes sense, is should there be a working group or a task force that's assembled that specifically addresses these and the other issues that have been brought to our attention, and over a limited period of time, creates a simple focus point, identifies it as a unique set of specific agenda, take these various points of the system, which could rapidly, from what you say, make our mental health community a better place to be and to work in and get results from, and put together a series of recommendations that seem to make sense, because right now we hear a lot of different testimony and everyone says -- not says -- says not the same thing. This is not to be pejorative of what you're saying, but there just doesn't seem to be an organizational structure that can attack it from a multi viewpoint perspective and do that under the ageas of having a solution-based

process at the end of which a series of recommendations can happen. And I heard about a Blue Ribbon Commission, but it sounds to me like that's something that would make sense. Does that -- yes or no -- make some sense? I don't need a --

SHEILA AMDUR: As long as it doesn't become the report that goes in the round file and the end of the process. I sat through that.

ROBERT DUCIBELLA: I second that, yeah. Thank you very much.

UNIDENTIFIED SPEAKER: I would add to that.

GARY STECK: I know that you didn't deliberately do this, but you didn't mention families and consumers, and I think that we have to remember that we are Connecticut. We all are -- we are consumers. We are family members here at this table, and that everyone needs to have a voice. And I actually took your comment in a different way because I think that this is an opportunity for hope and for change, and I don't think any of us ever dreamed that we would be here. But for those of us that are in this field, I don't think that any of us dreamed equally that we would begin to be able to talk to everyone about the day-to-day struggles of the families that we work with in a more comfortable, normalizing fashion where we're

encouraging people to get help early before it ends up being a bigger problem. So, I think that we remain hopeful. I appreciate your analysis, but I don't -- I think that we need to remember this needs to be done with consumers of services and families all along.

SCOTT JACKSON: Thank you. I want to take a -- thank the Panel for its excellent and insightful testimony. Thank you very much. Why don't we take a quick break, a seven-minute break. We'll reconvene at 11:15.

(A recess was taken)

SCOTT JACKSON: All right. Friends, why don't we reconvene. Next panel is Dr. Eric Arzabi and Abby Anderson. Thank you for coming in. Good to see you, and the floor is yours.

ABBY ANDERSON: Good morning. I am going to go first, and then Eric is going to go second. May it please the Commission, we felt we'd do our testimonies and then take questions, if that works for you.

SCOTT JACKSON: Absolutely.

ABBY ANDERSON: So, good morning, and thank you for the opportunity to speak with you. I'm here today, actually, wearing two hats. One as Connecticut Juvenile Justice Alliance, Executive Director; and two, as the Keep The Promise Coalition Children's Committee

Co-Chair along with Eric.

Eric is the expert in mental health, and he's going to focus on that while I'm going to talk more about how juvenile justice and mental health systems are related.

My focus is mainly going to be on things that aren't going well, but my intention is not to point fingers. We know that the vast majority of people in state offices, schools, police departments and those working for community providers are doing the best they can and want what is right for kids in community. It's the system themselves that we find broken. But the thing is I've seen Connecticut's juvenile justice system transform itself, so I know that when we work together, system improvement is possible.

I want to talk a little bit this morning about what we mean when we say children's mental health, explain why failures in the children's mental health system mean kids end up in the juvenile justice system and talk about why that matters both morally and economically.

Let's start with a question. What is a picture you get in your head of a child who struggles with mental health, a child who needs mental health services? In response to recent calls for a registry

of those with mental health issues, I've taken to saying, well, we do a census every ten years, let's just use that because mental health is a continuum, and nearly all of us will struggle with our mental health at one point in our lives. Some of us will struggle more severely or more often than others, but few will never struggle at all. When we, as a society, continue to think of those with mental health issues as an us versus them instead of thinking of mental health as a we, fear and ignorance wins. And fear and ignorance lead to shame, denial and bullying on a individual level and lack of appropriate services, funding and supports on a systemic level.

Think for a moment about your life as adults. We all hit rough patches. We have a sick relative who requires a lot of time and attention, a family member or friend dies, and we grieve. We go through a divorce or we suffer from depression. And when we go through rough patches as an adult, we tend to be distracted, irritable, exhausted and not that fun to be around. It's hard to concentrate at work. I think we've all had that coworker or family member go through something and be a bear to live with, but we think, well, his mom just died. I need to give him some space. But what happens when a kids guy through a rough patch? In all

of those scenarios mentioned, there are often children involved. And for the child, there are a lot of I don't knows. The child might not really know or understand what's going on. The other adults in the child's life, like the teacher, might not know what's going on, and the child might not know how to express his or her feelings or even if it is okay to express his or her feelings. And the child certainly hasn't learned healthy, productive ways to manage his feelings.

I have anxiety issues, and when they flare up, I need to go for a run or do a hard workout. I need to journal and seek out friends. I'm in my late 30s, and I've only figured out this formula recently with the help of a therapist.

Children certainly don't have those skills, and they rarely have a therapist. And while the scenarios we mentioned above about divorce and sickness are real and valid, we know that many children in Connecticut are also dealing with anxiety that results from worrying about having enough to eat or an arrested parent or witnessing or experiencing violence. And some kids or adults aren't experiencing serious mental illness because of a situation or their environment, it's simply part of their genetic makeup like the color

of their hair or their aptitude for math.

So, children are dealing with their feelings and their I don't knows, and their behaviors reflect that. They may be exhausted, irritable or distracted. They may have mood swings. Teenagers might start smoking pot or abusing prescription drugs. At school, an irritable, distracted and tired student is tough for a teacher. That behavior is most often interpreted as disruptive, unruly or bad. Unlike you and I being able to recognize our coworker is going through something and giving them a pass, the folks in the schools don't have the time, training, resources or incentives to think what's going on with this kid. What might be underlying his behavior? Instead, unfortunately, the child is labeled a problem and suspensions, expulsions and arrests tend to result.

Now, I don't mean to blame or demeanize schools. The vast, vast majority of personnel are doing the absolute best they can in a system that simply isn't set up, funded or resourced to help them help every child succeed.

So, what's the alternative? Imagine we have the knowledge, resources and time to ask what's going on with you and figure out how we can help. What if we could address the issue head-on now and help this child

understand what he or she is feeling, then develop some coming tools. What if we could help the child and those around him or her learn about self-regulating and prevent, in some cases, those issues escalating into true high-risk, high-need situations that end up in the courts.

Now, I know what you're thinking. Abby, that sounds really hard. And usually things that are really hard are really expensive. Well, changing how we do things is hard, and it takes money, but I believe we would find it to be a financial gain or at least neutral.

The juvenile justice system invests far more now in community-based front-end services than it used to, and it is now smaller and more effective than it used to be. Critically, even after the system put all of those funds into front-end services, the overall budget after inflation adjustments is smaller now than it was ten years ago, as you can see in this chart done by the Justice Policy Institute. And I see that the Mac to PC didn't work that well, but hopefully on your handout, it's correctly lined up.

So, I know that we can change effectively and efficiently. And as I said, the juvenile justice and mental health systems are very closely related. You

see, the mission of the Connecticut Juvenile Justice Alliance is two-fold. We want to keep kids out of the system, and we want to make sure that those who come in find a system that is safe, fair and effective.

We have lately concentrated on narrowing two paths into the juvenile justice system; education and mental health. And through our work, we've learned that the number of kids who are a true public safety risk, without underlying mitigating factors, are far outnumbered by the kids who have a lot of needs that when unmet or unrecognized, finally escalating to a point where they acted out or the other systems they were in simply gave up.

In terms of education, arrests in school occur much more frequently than most people realize. Last year they accounted for a full 19 percent of referrals to juvenile courts statewide. And contrary to popular belief, these arrests weren't from violent, drug or weapon-related incidents, but the vast majority were for minor, nonviolent misbehavior, typical adolescent behavior like fighting, smoking cigarettes, talking back and violating the dress code. Certainly, we do not condone fighting, disrespecting a teacher or disrupting a classroom, but we know that there are more effective and less expensive ways to address a young

person's behavior. We also know that the children most likely to be arrested at school in our state are the ones statistically most likely to be experiencing stress, trauma and mental health issues.

As this graphic, with terrific data from Connecticut Voices for Children shows, black children are four times as likely to be arrested than white peers in schools. Hispanic and special education children are three times more likely. And children in the poorest districts are nine times more likely to be arrested in school than their peers. Is this because children of color and children in cities are just inherently bad apples? Well, the research doesn't tell us that and neither does common sense. But common sense tells us that wealthier districts and communities are apt to have smaller class sizes, more support staff, and a broader array of resources.

There is a name for this phenomenon of school arrests that we don't use. It's called the school to prison pipeline, but I mention it here because it highlights a challenge. That term points the finger solely at schools to blame. But as I mentioned earlier, the whole system needs work.

So, how do we break down barriers between communities and schools, stop the cycle of blame and

achieve better outcomes? We have two recommendations to those ends. First, require memorandums of agreement, and second, improve data collection. If police are going to be in the schools, their role must be clear to everyone involved. Officers must not become default disciplinarians.

So, in some Connecticut towns, the superintendent, police chief, juvenile judge, Youth Service Bureau, D.C.F. and service providers sat down to create a memorandum of agreement between the police and schools determining roles and responsibilities, and they created a graduated response model to clearly outline how different behaviors would be dealt with, preserving arrests for the last resort, rare occasions. The results of that work are clear. In one year, Manchester reduced the number of school-based arrests 61 percent across the district. And Windham reduced arrests 34 percent across the district. Hartford and Bridgeport have also recently signed memorandums of agreement and are starting to see significant reductions in their student arrests.

Interestingly, we learned this process wasn't primarily about money. It was about communication. Schools would say, we'd love not to arrest for minor drug offenses, but we don't know about other options;

or when a child is out of control, we don't know what to do besides call 911. So, during these conversations, community members can often offer recourse and ideas. Eric is going to talk more about some of those resources, like the Child Health Development Institute School-Based Diversion Initiative, and it focuses on educating schools and school personnel about emergency mobile psychiatric services. We shorthand that in our office to say call 211, not 911.

Legislation that we testified for here last Friday would require districts to have a memorandum of agreement in place if they are going to have police in school. It's a great first step. It also requires data collection which we need so we know what's really going on. We have some data now, as you have seen. The courts have started collecting data which shows one part of the picture. And Connecticut Voices For Children did one year's worth of analysis compiling and sorting of SDE numbers, but that isn't feasible annually or realistic for a community to be able to mark its own progress.

But what does this have to do with mental health? We are arresting kids who could have been kept out of the juvenile justice system if only their mental health

needs were addressed. Do all arrested kids have mental health needs, and could they all have been kept out of the system? No. But I can tell you that one of the hottest topics in the world of juvenile justice nationally is making sure that systems are trauma informed. The percentage of kids in the juvenile justice system with trauma needs is remarkably high. Well over half the boys, and virtually all of girls in our system screen for having experienced at least one and usually multiple significant traumas. But if we know that so many kids in the juvenile justice system come in with trauma issues, why aren't we taking the steps to address those issues earlier instead of waiting until they get arrested? Isn't that like seeing the local playground covered with glass and instead of picking it up, stocking up on Neosporin and Band-Aids before recess?

Putting a child who already has trauma issues into a punitive system, maybe including stays at detention or another facility, can further traumatize him or her and negatively affect their future behavior. Obviously, preventing trauma in the first place is the obvious answer, which is complicated and a bigger issue than even I will tackle here, but there are certainly ways to deal with a child's trauma before they come

into the juvenile justice system.

As you have heard this morning, Connecticut has some terrific trauma services for children, but not enough. I recently heard a story from a teacher in New Haven. She mentioned offhand that there was a dead body outside of her school a few weeks back and how the police were there all day dealing with the corpse. How many kids at that school were not traumatized that day, and how many of them do we think will ever get the services they need? But what does that lack of services mean broader than student arrests? I know you heard from Vicky Veltri recently, and her report discusses something we hear a lot, that there are some community-based in-home mental health services for children that are evidence-based, but they are available on a small scale and not for everyone. Kids who don't get what they need may cycle from emergency departments, back home and back to the ER and then perhaps enter D.C.F. care, and, surprisingly, a high number of those who do enter D.C.F. care end up arrested.

In 2012, 451 youths in D.C.F. placement were arrested. That's alarming. More alarming is the fact that there is a 20 percent increase in arrests during the second half of the year. This problem is growing.

Now, let's remember these are young people who are removed from their homes because of abuse or neglect, by definition a traumatic event, kids who required residential treatment setting for behavioral health issues, and then some juvenile justice involved kids. And they are being arrested, often times, for the same behaviors that originally led to their placement. So, this tells us that even the programs and facilities that we have for our children and youths aren't currently providing the right kind of services. And so those kids who began their journey in state care because they needed just that, care, become delinquent, pushed farther away from help and opportunities. But that's not a knock against our juvenile justice system, and it's not to say that juvenile justice -- that the kids in juvenile justice system are a lost cause. But it's our job to help these children in removing the barriers they face in their lives, to help them find ways around and through the barriers their environment or mental health issues have created, not to create thicker, higher walls for them to scale, which is what we do when they put them in the juvenile justice system.

Now, I'm an advocate, and I can rightfully be accused of having a bleeding heart sometimes. So, I

went to the people in the juvenile justice system and put this scenario in front of them and I said, I really feel like you guys are dealing with a lot of kids who never really needed to be here. They have mental health needs, and we could have prevented their entering your system. So, tell me honestly, is my leftist tendency running away from me on this one? And they looked at me and said, you know what, Abby, not this time. You're petty on target. The kids we have seen have always had a lot of mental health issues. But the kids we deal with now, they have more complex needs than ever. Now, that's not good news, except in a way it is because as you're probably aware, the juvenile justice system in Connecticut is dealing with a new cadre of older youth for the first time.

I am very proud to have been part of the Raise the Age Campaign to get 16 and 17 year-olds included in the JJ System. From 2010 to 2012, this change has meant that just under 12,800 kids were kept out of the adult system. Now, it's great that we're keeping these kids in a system that offers both rehabilitation and punishment instead of a simply punitive approach. But when we talk to people in the juvenile justice system, we still ask, how many of these kids truly need the punishment piece of that rubric?

Let me be clear. There are kids who are a legitimate risk to public safety. Some of those kids may also have mental health needs. The juvenile justice system is clearly the appropriate place for them. But what about the kid whose mental health issues went untreated or poorly treated? I'm talking about a girl who was removed from her home at 12 because her mom's boyfriend was raping her. By the time she turned 15, she had been in six different placements, obviously never able to develop deep therapeutic relationships, and she's angry. So, at her latest group home, she gets into a fight with another girl and punches her in the face. Is that okay? No. But is this a kid who really needs the juvenile justice system? Is putting her in yet another system and placement really the way we're going to help her become a fully participating positive member of the community? I don't think so. We need to hold her accountable to her actions, but we also need to hold ourselves accountable because how much blame do we, as a community and system, have to shoulder for the situation she is now in.

Let me make one last point and circle back to when I asked you to picture what a child with mental health needs looks like. I'm going to guess that the child

you're picturing is white. When we look at the data, the kids in our psychiatric hospital, Solnit or Riverview, are more likely to be white. And the kids in our prison, Connecticut Juvenile Training School, are disproportionately black. Now, do I think this is because we're consciously racist and making consciously race-based decisions? No. But we are conditioned and trained in a society.

I have two brothers; one is black, one is brown. And when I picture the kid with mental health needs in my head, he's white. Even with a multi-ethnic family and an admittedly bleeding heart, I noticed these tendencies of thought based on stereotypes in myself. We need to make sure that our system is cognizant of these tendencies and consciously plans and strategizes to ensure we are making decisions about our views based on risk and need and not based on the color of their skin, subconsciously or not.

So, to close, let me quickly summarize my recommendations. We need to take action to reduce arrests in schools by collecting data and requiring districts with police to have memorandums of agreement. We need to significantly expand access to trauma services for children. We need to require D.C.F. to examine its continuum of services, its continuous

quality control and contracting procedures to reduce the number of arrests out of its facilities.

And I have two additional recommendations. One, we have to have systems that work together. We need appropriations to acknowledge and support collaboration and cooperation across agencies so that children don't fall through the cracks while agencies try to determine who is responsible for his or her care. Who pays for autism, D.C.F. or DDS? Who pays for programs specifically designed to divert children from court, CSSD, D.C.F., SDE? Agency heads have to be good stewards of their funds, but we have to stop putting them in the position of having to figure out which group of children isn't their responsibility, and we need better data analysis collecting and reporting.

For years, funds have been cut for anything that isn't direct services for children, which means that the computers at some state agencies are literally older than I am. Right now in Alliance, my giant staff of three is doing some of the data collection and analysis for the Department of Children & Families because they don't have the capacity. Now, bless them for working with us in that way, but shame on us as a state for needing a group like mine to play that role.

Without good data, how do we know what services we

need, what services are working? How do we know how and where to appropriate funds? Right now there are a lot of answers around children's mental and its overlap with foster care and juvenile justice that we just don't have, and that's unacceptable.

To close, let me say I know I've laid out a picture that is pretty grim. It's my job to always push the system to do better, but I am confident in doing that because I've seen Connecticut make amazing progress on the juvenile justice side, where while everything isn't perfect, we have come a long way and seen good outcomes and been economically cost conscious.

Connecticut has some amazing progressive programs for children's mental health, so I know that we have the ability to expand the reach of those programs. We have a solid foundation in this state, and we can build upon it, but a foundation isn't enough. It doesn't protect you from wind and rain. You need a roof and walls for that. It's time for Connecticut to build the roof and walls of its mental health system for children in order to keep those children safe. I'm going to turn it over to Eric.

(Hearing continues)

C E R T I F I C A T E

I, Christine E. Borrelli, a Notary Public and Licensed Court Reporter for the State of Connecticut, do hereby certify that the foregoing hearing of the March 12, 2013 Sandy Hook Advisory Committee was transcribed by me via electronic and video recording.

I further certify that I am not related to the parties hereto, and that I am not in any way interested in the events of said cause.

Witness my hand this 8th day of November, 2013.

_____

Christine E. Borrelli
Notary Public
RMR, RPR
CT License No. 117

My Commission Expires:
June 30, 2016