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MADELON BARANOSKI: -- find someone who had a long arrest record and had weapons charges and so on. Okay. So that's the feeling and that's the problem. The other thing is that we know treatment alters courses because we see a change in symptoms, but if we're always going to focus on violence as the outcome, we're never going to know if we prevented anything because we know when something happens. But we don't know when it didn't happen. Right? So -- and that's different from police. So police go to a -- somebody nearly jumping off of a building, and they interrupt a case or they interrupt a hostage situation. They're interrupting it. They didn't prevent it altogether.

In mental illness, I'm talking about preventing it. We don't know how many times our treatments worked. So I could say, "Oh, yeah, you know, we stopped a lot of these killings going on." And you could say, "No, look at your base rates so low, you didn't stop anything." You can't prove prevention on an individual basis. And our research has always had competing goals with treatment, right? So if I asked you or made the argument that we should get rid of airport detectors, metal detectors because they don't predict hijackings, in

fact, in very horrible hijackings, they didn't pick up the metal. And I go through and I always set it off. And I'm never going to hijack, so we should get rid of it. And you'd argue, no, no, no, they're not to predict an outcome; they're to detect a risk, a risk of metal. But our research, we look at the outcome of violence as a measure, you see, and so I'm going to take you now through something that may be a little tedious but kind of interesting, and if you're ever on Jeopardy it might come up.

So in that -- World War II, the British Navy developed a method of analyzing whether sonar on submarines was accurately detecting what was really in the sea around them. So that was the big issue. Could you tell when a real submarine was coming or was it a whale? And they developed what was called signal detection theory and analysis. And so the idea is there's a reality out there, and the thing around that submarine is either another submarine or it's a whale, and can that sonar detect it?

And what they wanted was a sonar that said, "Yup, it's a submarine" when it was a submarine, and "Yup, it's a whale" when it's a whale. And that's where we get the term "false

positives." So if the detection said that it's a submarine and it was really a whale, that's a false positive. If it said it was a whale when it was really a submarine, that's a false negative. So you've heard those terms, right? You go to get your TB shots or TB testing, this is the analysis they use to determine whether the test they're using on you is reliable and valid. Right? Or we say sensitivity and specificity. How many false positives and how many false negatives? And this is the analysis we apply to our work.

But look what happened. Over there, the scientists that were developing this, they wanted a lot of true positives and a lot of true negatives, and these were the mistakes.

Now, would that work in clinical practice? We would not tolerate a psychiatric system that sat around identifying high-risk people and then celebrating when they committed violence. What do we do? You see somebody who's high risk and you try to move them over into the no risk. And then you have a false positive on research.

So our work isn't to predict violence. It's to identify risk and mitigate it, manage it. But how do we know that we're working or doing it?

That's what we can't determine. We don't know how many times we've been successful in presenting or -- preventing something very, very bad. All we know is how many times we've reduced symptoms, reduced anger, hospitalized someone. In fact, we could argue when we put somebody in for suicide and then let them out, somebody could say they weren't going to do it anyway, and we wouldn't know for sure, see.

So the difficulty of determining the effectiveness of mental health services for those rare outcomes in populations that don't show common violence -- that odd violence that's associated with psychiatric symptoms -- is very, very hard to show. And I'll maintain we are making a difference. We are intervening. But we're intervening when they access treatment. You can't intervene when someone doesn't access treatment.

So the management of risk, then, begins with assessment. Assessment is part of risk management. It cannot be separate. And when somebody tells me "Oh, yeah, I did an assess -- a risk assessment, when he first came in three years ago," I know they don't understand what they're doing. Risk assessment takes place every time you

see somebody, how they changed, their risk for their discomfort, their suffering, their risk for symptoms without worrying about whether we're predicting an absolute episode.

Assessment also allows us to look at the management of treatment and to figure out the next step. So a man who is always in trouble and gets into fights and even threatens peoples with knives but it always happened when he was homeless, on drugs and off meds, and we get him hospitalized for a little bit, and then we get him housing, and we get him in the drug treatment, and then we say "So what's the next step, now? What's the next step?" And that's what assessment tells us, how you layer the risks. Take them away one by one based on what's the most severe but also what's the most accessible to do.

Assessment allows us to monitor the mitigators and exacerbators. Are problems getting worse or not? Is the child being bullied more in school now because he was put in special ed than he was before? And bullying was associated with the fights that he had in school. So a solution, now, is never seen as standing independently without an assessment to see if it worked. An assessment has

to include all measures.

So I would never agree that we should use actuarial measures, but we should never use them alone on a psychiatric population. The clinical risk assessment, you've seen this before. That is also a guide for treatment. We identified the target prob -- Ignore the letters on the side; that's just a formatting issue. You don't have them on your paper. Are we looking at long term or are we looking at a person right now? Are we predicting whether this person should be housed on a maximum security which is something that DOC would be concerned about, or are we looking at whether they can leave the hospital today? Different questions.

Discharge placement and level of acute care: What do they need in the community to maintain their level of mitigated risk? Just because they leave the hospital doesn't mean all risk factors have gone away. And are we consulting? Are we doing clinical management? What is our role in identifying risk? And all of this guides how we do the assessment and make the recommendation.

Now, I just want to talk about harm reduction because harm reduction is a very useful idea in substance abuse. You reduce harm, you

reduce the things that make a person crave for drugs, you begin to whittle away at as much of the risk as you can, knowing there may be a core of risk you can never touch. So in harm reduction, we look at titrating risk with appropriate services, putting as much in place as need be to bring the risk as low as we can. And in high-risk patients, we want to try to increase the mitigators and reduce the aggravators. And there are a lot of aggravators when you're homeless in a community craving for drugs with a psychiatric illness. And so to reduce risk, much of our work is at stabilizing a person's life. Now, again, we can't prove that they would have done something horrible, right? But we know we've reduced the risk when we've treated.

We target the interventions to specific risk. Every intervention should be addressed at increasing the person's functioning and reducing the risk. So the harm reduction goals are these: We need an identification of specific factors that alter risk level for every person that we're trying to treat, and that means information beyond what we can collect. The incorporation of substance abuse treatment needs to be considered. And substance abuse treatment cannot end when a person is sober,

even for several months.

People coming out of prison are still craving drugs, even if they've been in for years; especially when they get back into the neighborhood where they used the drugs before. And so substance abuse treatment is a way of talking about low frustration tolerance, impaired coping skills, and a fast and accessible fix. And, unfortunately, drugs are more accessible than treatment. And actually, drug dealers employ more readily than most other jobs that we have as well.

We need adequate information. What's included is always a weapons assessment. Not only firearms, but weapons. Do you have weapons in the house? The answer to that is always, "Yes, of course," but a person who says, "No, I don't have any," you know, they haven't thought about weapons in general. They've thought about it in a very specific way. Environmental and social stabilization: We need to decrease isolation and increase access to treatment, increase access to consultation for those who aren't the patients, to families and others who have questions. And we need to increase helpful eyes-on; not policing eyes-on, necessarily; helpful eyes-on.

Now, the way to do that -- And I know -- I understand HIPAA -- So I understand what the rules are about this. But one of the things we need to start looking at is why it is so hard for people to see mental illness the way they do a common cold and a sore throat. So we have all these docs in a box run up and people are always going in asking for antibiotics. There's no shame in that, is there?

But there is so much shame connected with mental illness. That stigma we've not -- we've eroded a bit, but we haven't removed. The same thing was true when AIDS was first diagnosed, and we've come along way with AIDS, with people being able to say, "Yes, I have this and I'm going for treatment." And that took a lot of concerted effort and collaboration from the community level on down.

This is a poster that's put out by NAMI and by APA, American Psychiatric Association. It's in airports across the country right now, and I thought it was a very nice way of sort of being in your face saying, "Come on. Think of mental illness as a disease." Those kind of approaches will allow parents to identify their children as sick, not as bad and identify and allow people to think, yeah,

maybe this is more suffering than I need to do, even though I know I'm right and the rest of the world's against me, but I don't have to suffer so much with that. So changing the culture around mental illness is one of the approaches that will increase the ability to access treatment, the ability to have eyes-on, the ability to work collaboratively within a community. Okay.

I'm going to turn -- I'm going to let you finish.

MICHAEL NORKO: Okay.

MADELON BARANOSKI: I'm going to turn it over for the last stage.

MICHAEL NORKO: All right. So we have a few models of risk management. One of the things to -- to note is that when we talk about risk, risk is not a unitary concept, so we have to talk about the probability, also the imminence and the severity. So the severity is actually best defined by prior violence. So we usually think if someone's committed a certain level of violence in the past, they're certainly capable of that violence again in the future. If you're trying to define what the probability or likelihood is, that's probably still best defined by actuarial, but

imminence really has to be sort of a clinical in the here-and-now kind of assessment.

The risk -- The basic risk of management approach is we identify what are the needs and deficits that the person has that create the risk, and then we try to target those needs and deficits with interventions, and then we monitor what the effect is; and we adjust what we do based on what we see, we give people increasing opportunities, and we monitor how they do with that, and that's how we continue. Paul Mullin says it in a very similar way, but his chart here is probably easier to go through. So down here we have this is the probability of violent behavior. So if we don't recognize it, we can't do anything about it. But if we recognize it, then there's all sorts of things that we can do. We can try to decrease situational triggers. We can try to decrease substance abuse. We can try to have an impact on decreasing symptoms of the mental disorder. We can try to improve social and interpersonal protectors, try to decrease social and interpersonal stressors, all of which leads to a current state of mind that will be more conducive to not responding to situational triggers; but we could also try to do something about those.

The thing that we can't do anything about is the preexisting vulnerabilities, but that's only one element here, and everything else is what we work on in a risk management plan. I won't bother going through that; you can look at it. One of the problems that's been recognized very recently in our literature is that although we have a lot impressive science and we've made a lot of improvements in the last 20 years, our science actually lags behind our clinical practice. And the reason is that we haven't really identified causal dynamic risk factors for violence in a way that shows us how to intervene. And as these authors pointed out, there are a number of these that we need to look at as potential objects for us to study and have -- and develop ways of looking at them in terms of tools so that our tools would be -- wouldn't be limited to historical factors, but they'd be more useful. I won't bother going through the summary slides because you've now heard it and you've had a long day, so we'll stop there and see if there's any questions we can answer.

SCOTT JACKSON: Thank you for your very thorough presentation. Do we have questions for the panel?

I have one quick question. There were a number of specific tools, assessment tools identified about halfway through. Those are tools that are to be delivered in a clinical environment. That is to say, are they of such depth and complexity that, say, a crisis team operating in a school, it would be an inappropriate tool for them?

MADELON BARANOSKI: Some of them -- The HCR is used on a unit, but they're for adults. So applying them to children, you'd have to be sure that you're picking up the appropriate behaviors that children show compared to what adults show. So there are some child measures, however, that look at impulsivity and mood changes and so on that could be done in a school. And all of these can be done in a clinical setting, all of the tools. But they need access to past information if they're the actuarial tools.

MICHAEL NORKO: And the cover, for example, is one that you actually have to buy as a computer program because it guides you through -- It's based on -- It's based on the iterative classification tree, meaning that you ask the first question, you put the response from the individual; depending on what the response was determines what

the next question is. And you keep going down a decision tree with the computer deciding what's the next best question to ask to start separating as to whether or not this person's low risk or high-risk. So that requires something that you have to purchase.

HAROLD SCHWARTZ: Thank you to both of you. As somebody who's tried to lecture on risk assessment and low-base-rate events myself, I have to say that that was a tour de force and greatly appreciated, the very best I've ever heard on the subject. And so I have a comment and a question, a comment to the commission. So imagine the difficulty of risk assessment using these sophisticated tools and methods of analysis, and now imagine something like the reporting requirement that was incorporated into New York State's gun law. And I raise this just for when we get to our deliberations about the possibility of reporting requirements, that the notion of asking clinicians out there to simply make judgments of the potential dangerousness of their patient with no further guidance and then to actually report and have people's names go into -- go to public agencies, I mean, it's just -- you know, it's breathtaking to

think how useless, you know, such a requirement would be. So that -- that's for our discussion further down the road.

But I have a question for you about a special population because we come away from these lectures or presentations on subjects like this with the -- with the general belief that individuals with psychiatric illness are no more dangerous than other populations. But then we -- you know, we learn there are subsets if you have -- if you're untreated and you're using substances. One particular subset I would just -- I wonder if you have any thoughts about are the untreated first episodes, people who are in what -- that researchers call the -- I'm sorry. I'm losing my thought here. During -- Oh, the time to first treatment.

So there was a review article recently, I think it was in Schizophrenia Bulletin, that indicated from a meta-analysis of studies of that population that a group of people, untreated, undetected illness might be at as much as 600 times higher risk than the general population. All of the studies or most of the studies that contribute to the kind of research that you are using here are studies of people from a period -- from an episode

of treatment. The MacArthur study, for instance, follows people from psychiatric hospitalization over the course of a year. Now we're talking about people who have never been detected as having a psychiatric illness going from perhaps the first point of symptomatology, if it could be determined retrospectively, out to the first episode of treatment, and that population's very different. Can you speak to that?

MICHAEL NORKO: So the epidemiological studies, for example, don't necessarily start with identified patients. So the epidemiological catchment area survey was really a question about the prevalence of various kinds of mental disorders in the population, but because it had within it all those questions about, have you been in a fight with someone else? Have you hit somebody in the last 12 months? They were able to take the questions that were answered about various symptoms and come up with diagnostic profiles related to that and then compare that to the symptoms. So these people weren't necessarily identified patients, but they had symptoms. In the Washington Heights study in New York, they were actually very specific about finding people who were

not identified patients, but who were nonetheless psychotic. And in New York City, they had enough of those to find that they could actually study them and get statistically meaningful results from it. And what they found was -- because they were sociologists who were doing the study, they were interested in trying to figure out whether this was a labeling phenomenon. Was it the idea that because you were labeled as a patient or because you identified yourself as a patient that somehow that had to do with whether or not you were violent?

And what they found was it didn't matter whether the person was a patient or not a patient. What mattered was whether they were psychotic or not psychotic. That's the only data that I can think of to bring to bear on that, obviously not through the longer period of time that someone remains psychotic that they've not been identified, it increases the risk.

MADELON BARANOSKI: I think I do know, though, that I think Dr. Schwartz might be referring to the study: On average it takes two years from the presentation of symptoms to when a person accepts treatment. They may flirt with treatment a little bit, but in general -- and that

had 600 times the period of violence. But I thought the comparison was to the whole other period of with schizophrenia. I may have read it wrong. So that it's the most violent time in schizophrenia, but overall the violence of schizophrenia is still low, but that's the critical time when the person first develops symptoms up until the time they accept treatment.

What's interesting is the court often is the case finder on those, and not for major violence but for peculiar things like for an odd breach of peace because the person is acting peculiarly in a coffee shop or something or is threatening. But then it's dismissed very quickly because they have no previous history, and they're not interested in treatment, and it's not a big thing. So our diversion program had picked up young people for whom the disease is not completely declared. It takes a while for all the symptoms to manifest, and so it's a very complicated period, and they are different. I think that is different.

HAROLD SCHWARTZ: And I may have misread the com -- the comparison group was the general public or --

MADELON BARANOSKI: Other than

schizophrenia.

HAROLD SCHWARTZ: -- who were in treatment, and I apologize to the commission because I meant to bring that article with me today knowing that you guys would be making this presentation.

But the point is, merely -- I mean, we are talking, you know, about very hard risk to assess in either group. The point is I think for us that it heightens the importance of early detection and early intervention. It says, you know, if -- within the individuals with psychosis, you know, as a group in its entirety, the risk is enormously higher in the untreated group, particularly never treated, living through that period of first symptomatology to first coming to -- to treatment. And so as we focus on recommendations, with regard to the importance of early detection and early intervention, I think it's just -- it's further evidence of the importance of that.

MICHAEL NORKO: One thing to add to that, just recalled is the stranger homicide study. The vast majority of the stranger homicides were committed by people who were not in treatment. There were -- 42 episodes that they were analyzing, and only five of those were by people had been

engaged in treatment.

MADELON BARANOSKI: One of the things responding to that is, often when the symptoms first emerge, the person is engaged in something that promises a future. They might be in school; they might be at work. And the response of the outside world is to shut them off. So they get in trouble in school, they're not passing grades, and they're failing out -- and often it's college. When we had the draft, you'd see it at boot camp, and you'd see young men returning with psychosis. So the way to pick them up often is to make treatment acceptable, not only accessible, but acceptable. And right now it's sort of a failure of your future, which is a very painful time.

HAROLD SCHWARTZ: Now, that's another great point. And I think we all clinically, you know, are aware of it in the young man with schizophrenia who finally comes around to realize that he's not going back to school, not going back to the job he was on, in fact, is living with his parents and -- or on the street or whatever. But realizing it really for the first time. Very, very high risk period for suicide, but sometimes also for other-directed violence. An important point to know

clinically -- I don't know how that works into risk assessment tools, but very interesting and important issue.

MADELON BARANOSKI: Well, it's often hard after these tragedies to focus at all on the agony of the person who did it because the agony they've caused is outrageous. But if we focus for a moment on identifying people who have fallen off of their trajectory to normal life and outreach to that group, that group is going to have a number -- at least in our recent experience is going to have a number of those people who end up expressing schizophrenia later, undiagnosed at that time, untreated and at higher risk.

HAROLD SCHWARTZ: And, again, a little bit more important to try to keep people from falling off that trajectory. That's why we're focusing more and more on young adult programs, late adolescence and young adult and intervening with the first -- before the first episode of psychosis whenever possible.

SCOTT JACKSON: Thank you. I think we have time for one more question if anyone has anything for the panel. Ms. Keavney?

PATRICIA KEAVNEY-MARUCA: I want to

thank you because I found that presentation excellent. But what I take away from it -- and correct me if I'm wrong -- is that there's no way to predict. And, you know, you can't -- I mean, not there's no way to predict, but there's no way to isolate a certain population. That's just not going to -- It's just not relevant. It's not going to happen.

So the more important thing is to do what everybody today has -- every presenter today has suggested, that we have to reduce the stigma so people access mental health without feeling that they failed in some way and they don't fall off that trajectory. But in the case of the shooter at Sandy Hook, a lot of these manifestations were present, the isolation, you know. So even if we had some kind of program to put eyes on people like that, he would not -- we wouldn't have caught him before the act, it seems. And so there are a lot of unanswered questions, but as a society, we do need to focus on the how hurting, the how much suffering these people are undergoing and how do we help them, let them access treatment without feeling the stigma. Not a question really, just a little editorial.

MADELON BARANOSKI: That was a good

observation. I will say that a label can be as much of a silo as a place. And so a label, unless it has a cure attached to it that you can do, does not address the need of a person to develop their own self-esteem, their self-worth, their connection. And so the early identification is important, but the early identification along with supports to develop specific talents is going to be also another piece of that.

We have a number of patients at our Connecticut Mental Health Center who do incredible art. It was only identified after they've been a patient for a long time. Once they were identified as special needs, the avenue to express one's self and develop as a person got cut off. And so the early labeling is important, to be sure, but it's to be sure they get everything they need, not just a treatment that doesn't cure. That's the other problem.

SCOTT JACKSON: Thank you very much for your presentation.

Friends on the commission, we've had a couple of days of testimony on mental and behavioral health issues. If you're able to stick around for a little while longer, I'd like to kind of start to

discuss where -- what we're going to look at. We've seen a lot, and we've seen more than we can probably really grapple with, and this is just day two. So in terms of focusing our efforts in certain directions, we've heard some common items, we've heard -- we've heard in large measure that the system is limited, somewhere between limited and broken, depending on who we've spoken to. We've heard that there were financial issues intertwined with a lack of providers and lack of access and failure to fully extend appropriate practices. We've heard that it's impossible to project violent behavior. We've heard that early intervention yields positives results, and we've heard from some programs, and including points of interaction, be it law enforcement, be it in the schools, where we can hopefully start to develop some tools to recognize issues and provide an impetus for developing communities that feel. I think that's the language I think I stole from Alice, but that can help prevent this, because ultimately that is our charge. Our charge is to take a look at a certain series of improvements that can be made in a number of different areas that can prevent something like this from happening again. So if you can stick with it

for a couple more minutes, I just want to hear where you want to go, where you want to focus. Do you want to focus on children's issues? Do you want to deal with the whole structure? What are folks' thoughts?

SPEAKER: First of all, this is one of the most excellent presentations I've heard, and it really puts a lot of our thoughts in context. I think that you're not going to get all the dollars you want; we know that; we have to be somewhat pragmatic, and I think our best effort is to focus on younger people and the early identification and treatment up through adolescence and through school. You know, to me that's the best place to get them while they're young, identify them as soon as you can, recognizing, I know that schizophrenia's one of those things that doesn't kick in until later, but I think the more you can do with the earlier age, the better off we are.

ALICE M. FORRESTER: I just want to add on there what the doctor's last point was, that it's not just identification and labeling, but also really understanding the complexity of needs. So it's not just mental health or psychiatry, but it could be housing or poverty or sexual abuse or, you

know, the complexity that the child might be exposed to.

ROBERT DUCIBELLA: I can't get over the constant repetitive and extraordinarily well-documented concern, whether it's young people, which I agree with Bernie on that seems to be the targeted population statistically, or whether this is a matter of addressing issues of a socioeconomic nature that then have a potential predictor affect. I'll set all that aside.

I keep hearing that the system is very, very difficult to understand and access. I keep hearing that over and over and over again, and it would seem that we would have some obligation to make some statement about and institute some process for the eventual opportunity for there to be a means for people to access mental health in a way that is at least more comprehensible and more affordable. Those are the two things I've walked away with.

KATHLEEN FLAHERTY: I think -- And clearly because of the event that happened, I think there is a big discussion about focusing on younger children and intervening as early as possible, but I think we have to change the discussion of the culture of all folks who are living with a mental

illness, and I think that is the whole age spectrum. I mean, can we change this whole entire broken system? No. I mean, there's no way. But I would like to see this commission make a pretty definitive and pretty clear statement that we believe the culture needs to change, that the stigma needs to end, and we really need to change the way Connecticut treats folks with mental illness and that would become part of a community. Like I said when Eric was here, that idea of school connectedness is wonderful, and I would love to see community connectedness statewide, not just in the schools.

DENIS McCARTHY: One thing that concerned me is the statement that this has been subject to a review and analysis by a Blue Ribbon Commission in the state in 2010, which was not that long ago.

SPEAKER: 2000.

DENIS McCARTHY: Oh, 2000. Okay. But still, what were the recommendations of that commission and do they have relevance today, and should we retrace some of those steps in a presentation to understand what had got an exhaustive study before we maybe make the same

recommendations that, unfortunately, might have the same outcome.

SCOTT JACKSON: And on that, just from a process standpoint, our deliverable in this is defined by us. And by that, I mean we don't necessarily have to put together a list of 1200 independent items to fix the system. We can say you know what, that needs work, and it's really beyond the scope or the skill set of the people at this table at this time. But the creation or the review and analysis of that report may very well be a very credible recommendation. Does someone -- Dr. Schwartz?

HAROLD SCHWARTZ: Well, I agree that -- I think that we ought to say something about mental health and mental illness and services for everyone across the spectrum. I think we can do that but still decide that we want to focus or emphasize a younger population. And by the younger population, by the way, I think we have to be talking through young adulthood because so typically, the onset of the major mental illnesses -- illnesses can go through 25, 26, 28 years of age even when you think of that adolescent-to young-adult period, I think when we're talking

about the younger people. But I think a focus on that is relevant, it's going to -- I think we're going to be -- we're seeing that nationally in the national dialogue on mental illness that's getting going. I think we can do it, but I think it would be a mistake to not embed it in the context of a larger overview of the entire system.

And I've just been starting to think today, you know, I served on that Blue Ribbon Commission in the year 2000. And if you ask me now, could you please just highlight, you know, what some of the major recommendations were, I would have to take a pass, go to the men's room and try to find it on Google.

So I, you know, some of them -- I'm exaggerating a little bit, but not by that much. I think it would be an interesting starting place if we were to build in a little bit of time to relook at that -- at that commission report. One of the things I was saying to Ron yesterday, this was one of the things I know that was in there was the notion of a crisis intervention unit for children and adolescents -- we have the unit, and it's called "Cares" at the Institute of Living -- came in part out of that Blue Ribbon Commission, but if I recall,

the commission recommended several of those units around the state, and to this day there is only one. And I think when we think -- you know, I keep beating the drum about access to beds, and I know that's not politically correct, and it's not popular, you know, with many, you know, of the advocates and nor is it really financially feasible. But an additional Cares unit is something, I think, that this commission ought to look at, and it would relate back to the recommendations from the commission in 2000, and it would address the needs of young people.

ALICE M. FORRESTER: I just want to also point out if we're focusing on children or young adults, they're all looked within the context of a family. And, you know, that's -- one of the problems that hasn't been discussed today is that, you know, we silo not only, you know, different treatments, but we silo individuals and family, and there's really no sense of the whole family and what the whole family needs.

So if the parent is suffering with, you know, their own illness, you know, sometimes the kid gets the treatment. Actually, we've done a big study of a thousand moms in New Haven and, you know,

77 percent of the moms bring their kids to treatment; they, themselves, only 25 percent also need help and don't get it. So I think that we could sort of look at the whole -- And also a lot of the 25- and 26-year-olds that you're identifying, a lot of them are parents. Unfortunately, a lot of 16- and 17-year-olds are too, so it doesn't cut out, you know, studying the adults in the complex of children.

ROBERT DUCIBELLA: With respect to the deliverable, I think there is a fundamental decision to be made about whether we focus on highlighting areas of obvious need, which would be a listing of many of the things that we've heard in a consolidated fashion or whether you take that to a higher level of maturity in terms of coming back with recommendations. So I think some of the other subjects we've had: Safety in school, security or the gun law provisions, we had, I think, opportunities in the safe school design environment that put together a series of things that were relatively speaking easy to codify but maybe hard to fund, but they're still easy to define.

In the gun law issue, I think there were a lot of -- there were a lot of issues that were

very clear that we felt ought to be implemented, but there were political positions on those, and some favored them and some did not. But it wasn't a question of lack of understanding. It was a question of difference in support. You know, I don't think that there is anyone on this commission who doesn't have a very active neural network, but I find myself on this one subject much more adept in identifying a lot of things that we've identified as deficiencies and very inept at identifying what the specific recommendations ought to be for those.

And so as we move forward, the investment in time that this group makes and therefore the consequent fidelity in product that we produce is a fundamental discussion about how far do we go in identifying things that we want others to solve in other environments with more talent, more time and with or without funding, and we bring those to say after X number of weeks of testimony, here are the things that really need to be addressed, and then that is then passed on as a baton or whether we say here are the things that need to be addressed and here's the things we think we ought to do about it.

I bring that up without a

position -- I'm agnostic on the position but it's what I feel at this particular point is cognizant about you saying in a chair, how far do we want to take the document? And that's my initial impression on that. Thank you.

ADRIENNE L. BENTMAN: I think that one of the -- one of the things that they've offered to us are several frameworks with which to think about mental -- about mental illness and thus our recommendations, and that would in some ways tie into what you're describing. So when we think -- and I'm going to tell you what I think those frameworks are, and then we can look at each of them and decide whether there are literally things that we want to make a recommendation about or whether we want to recommend that we turn this over to someone else.

So, for example, one framework was offered today, and we've heard several conversations about it, and that's the issue of access to care. So the elements of that were stigma, accessibility, acceptability, preservation of dignity and affordability -- that may be under accessible. So that's one umbrella with which to think about on what we've heard.

Another umbrella to think about it would be let's just call it risk assessment. So I would put threat assessment under that, I would put care and communities under that. And there may be -- I'd have to sort of review my notes. But that's risk assessment, threat assessment; that's another umbrella.

A third umbrella is what I'll call the life span. So the life span begins with healthy parents and zero to three and early intervention and schools and, you know, school communities and then, you know, you sort of take it through the life -- you know, you take it through the life span. And we can -- If we think about what we've heard ultimately under those umbrellas -- and there may be others I've missed -- then I think we can think about what belongs to someone else, and what we actually might want to make recommendations about.

CHRISTOPHER LYDDY: You know, as I first came onto this commission, was appointed, I thought I was going to have a very different approach to this conversation being a social worker. But the conversations we've had today, what we learned today really opened my eyes to something that I think I really needed to hear and that there

are best practices, there are evidence-based practices, we know what works. It's really about that access and decreasing that stigma. And that wasn't a priority for me when I first came on this commission, this idea of the stigma being one of the most -- the most difficult barriers to actually accessing treatment. And the Newtown Police Chief last night, I think, was quoted as saying, "Precious time is precious lives." And he was talking about guns, but I think the same standard holds true with accessing mental health care and services. And so whether or not we're talking about those people committing violent acts or not or just achieving a well-being and wellness, to me it doesn't matter. I think the important fact that we have to look at is this bottom-line common denominator of wellness for communities and for families.

And so, you know, I think that we really need to address this idea of stigma and not make it a campaign to address stigma, but really to make it a fabric of our communities. You know, for me, as being a former politician, campaigns begin and they end. This is not something that I think should begin and end. This idea of addressing stigma

should be forever, and we need to really create a culture of acceptance and understanding for people with mental illness that I think we're so fearful of doing.

So, you know, to me I would reprioritize some of what I thought initially as kind of identifying best practices and evidence-based practices and move up this idea of addressing the stigma and the quick access to care.

PATRICIA KEAVNEY-MARUCA: I can't stop thinking about Alice's comment earlier today where she said in the car she thought about, you know, the one thing that came out of Columbine was don't protect the exterior, get in there so you save precious lives and what's the one thing that might come out of this commission or the three or four things that might come out. And I'm thinking about that in today's time where, you know, the UConn girls just made national notoriety, and two Connecticut hockey teams are going to compete. So Connecticut's like in the forefront in some areas. Why can't we shoot for the stars? Why can't we put forth a recommendation that maybe is not attainable in perfection, but this is what we'd like to see -- we would like to see every town have one or two

schools be these centers of healthcare and use all day; it's the hub of the neighborhood; it's the hub of the community where parents can access mental health support if they need it or they can access social work services. And if they can't -- No, if they're working, that's wonderful. But if the day -- if they can't do it during the school day, at least they can go there.

You know, the real concrete suggestion along with what Chris just said, not necessarily campaign but a real commitment to cultural change that reduces the stigma so that people who have issues with mental health don't get singled out and feel comfortable and accepted and know -- you know, just like a physical illness. So I guess in summary, it sounds like Pollyanna here. But I guess in summary what I'm saying is I would like to see us, at least in draft form, take away all the limits. Maybe we could put them back in, but what would be the ideal? And let's shoot for that.

HAROLD SCHWARTZ: Yeah, I think that is raising a central question. So the Blue Ribbon Commission that was formed in 2000 had a charge to look at the system and actually come up with recommendations that could be enacted to

improve the system to the degree that it was conceivably possible. I think we do have to step back and say, well, was that our charge or might our charge be to describe an ideal universe? And then let others see how far we are from that ideal universe and what parts of it, you know, might be achievable in the practical world now and what parts might be achievable in some practical world some -- you know, years from now.

The other thing I'd say is that we do have several other days of testimony and issues on mental health to come before the commission, so whatever we say in this discussion, we shouldn't leap to premature closure on where we're going to go. We need to hear the rest of this.

SCOTT JACKSON: Absolutely. The goal was actually to hopefully help focus and streamline those presentations in a way that fits where the commission would like to go.

I got a Q, and we'll start with Dr. Schonfeld.

SPEAKER: And, again, I'm sorry. I had to go take a call, but I think the -- I agree that we shouldn't have limits on what we aspire to, but I do think we should have focus on what we focus

our recommendations on. So it might be that in a preamble or in an introduction, we might say, you know, the ideal goal for trying to address these issues would look at these ten areas. And we could see models might be all integrated. Our commission has chosen for the purposes of this report to focus on two or three areas that we think have either short-term -- short-term opportunities or perhaps have long-term aspirations, but in a focused area. But I think if we are too broad in the scope of what we do, we won't have the opportunity to really ask the questions that we need, nor will we come up with recommendations that will be any more impactful than part of what's already been said before by other people.

And so that's the concern that I have is, and, you know, I was asking where am I even supposed to focus my questions? What are we trying to get out of the different testimony that's here? Because there is a lot good things being said by people who know a lot, but it's a very broad area. And I don't I don't know where people want to focus their energies, but I'm concerned if it's too broad, it may be kept there as a wonderfully written document, it might not be thrown out, but I don't

think it will actually change the lives of children in the state of Connecticut unless we're able to focus it, so --

SPEAKER: I can't agree with you more. Certainly all of our time and energy should be at, you know, great impact. So I can agree with you very much on that, and I guess I'd -- I just want -- We get trapped a little bit around this conversation that it's mental health. You know, we put gun control and mental health together, and, you know, to relegate the conversation on the mental health system, it limits, then, the conversation around the education system or social service system or the judiciary system. So I don't mean to counter what you're saying as, you know, get narrow, but I also think we can't get too narrow because this -- the conversation around stigma and community needs to happen well before the mental health disorder or the symptoms are exhibiting.

So in a lot of ways we have to maybe change the conversation a little bit. It's not mental health that we're trying to fix, but rather quality of life. Increase the eyes-on, you know. You know, one of the problems, you know, in the 12/14 event was, you know, the shooter had no eyes

on him. And, I'm sorry, I'm making some generalizations from the little bit of data that we have. But the reality was that this kid, you know, no one saw him in -- visually or connected, and so it's creating a community that tracks and understands when -- You mentioned earlier the drop-out, the eyes off. And so schools have to do it. We've heard over and over again, it's a threat assessment, a risk assessment is the fire department, is the police, is the social workers, is the educators, it's everyone together. So creating a model for that. And, Bob, about your conversation, do we create a model or suggest a model or an answer or not I think is on the table, but maybe we could suggest a model that -- you know, or bring in some experts who might be able to help us make a recommendation for a model, so --

SPEAKER: I'm going to try to build on what David has said and what I think Adrienne has said and others have said. If we want to start out with creating a framework for this document being rational, credible and esteemable, we need a mission statement, some kind of a chartered mission statement up-front that aspires to the goals that are talked about. I think that has real purpose,

and I think it's extraordinarily valuable. I think to David's point, though, if we just stay at that very, very high 30,000-foot level, we'll never grow any crops because we won't have the focus that we need on individual issues that need to be addressed.

So I'm not proposing this for your general consumption, but it sort of seems from listening that some sort of a very, very appropriate high-level mission statement that attempts to codify a number of the things that we hear aren't right that should be made right. It seems like a very good up-front way to posture the circumstance. We've heard a lot of testimony; everyone is conveniently saying that things aren't what they should be, and so we as a commission have an opportunity to bring that into the public forum and also say what we hear about it that should be fixed; that's "A." "B," I think there could be a number of focused areas open for discussion, as David suggested. Okay, let's take of the ten things which are in our mission charter, let's take three or four or five or two or three that we really think are most important and subject those to recommendations if we can agree on them. And then those that remain that we can't reach agreement on simply because we

don't have the testimony, the time or the intellectual resources to address, we suggest need to be addressed as a follow-up program at least there's a statement, there are a series of hot-button issues that we can make recommendations on, and then the rest of the issues aren't lost in the weeds because they've been published, they've been identified and we recommend a way forward for them. And although we can't address them with fidelity, we leave that as a chore for someone else and as a charge. I'm not being specific, I'm being process-oriented in a discussion; that's all.

SPEAKER: I just wanted to let the rest of the commission members know where we stand in terms of invitations. We've got invitations out and a number of confirmations for two-and-a-half other days. And hopefully everything that any of the speakers do will be incremental to what we've discussed today, so I'll be happy to share that information with them.

Those of us who planned -- got through some of the mental-health-related events talked about focusing now on adolescents and young adults, so that would be young people up to age 25, they're looking at the mental health system for adults over

25 years old. We have a commitment from attorneys at the University of Virginia School of Law, John Monahan and then Professor Bonney? -- Is there a link between mental health issues and violence? And what is the place of leverage coercion? Which we will learn to understand.

We have sessions committed for addressing trauma, and also some of the legal issues, mandatory reporters and legal issues. So at this point, it looks like two-and-a-half days; you might all recommend that we need to consolidate more, maybe insert other sections in there, but just to give you a sense that I think everything you're mentioning today does help to augment the rest of the schedule, and we can start to identify the gaps.

Our committee started talking about school culture issues; we did get into a little bit of that today, but there's so many other topics that this whole commission could explore, not necessarily mental health, but one thing does leads to another in our discussions.

And just to add one other point, while I wasn't on the Blue Ribbon Commission that Dr. Schwartz mentioned, I was in the room and know exactly where to find a hard copy and know some of

the people who were involved who are still working within the system who I'm sure would be thrilled to be invited back to sit.

SPEAKER: Just a language clarification because you had mentioned we were focusing on mental health and you want to be broader, and I guess what I would say is that I consider that we haven't been focusing on mental health today; we were focusing on mental illness more. And that really, if we were talking about mental health, which -- and this is just common language -- people interchange them, and I do think I would completely agree with you that what we need to do is actually focus on mental health which involves both how you promote health.

So one of the speakers actually defined what mental health was and then defined mental illness, and so I thought that it would be nice if we could take that perspective that what we want in our schools and in our communities is to promote mental health, and that involves the identification of mental illness and its appropriate referral and treatment or treatment or early intervention in school settings.

But it also is a conscious attempt to

promote the health, the mental health of children through forming connectedness in their school, forming relationships, helping them learn social and emotional skills and creating more resilient and competent individuals. And I think if we do that, that's going to be broad enough, but we might -- But that's, I think, one of the -- We seem to be spending some time on the mental -- the intervention for mental illness, and so I think that's an appropriate topic. I would just like to know if that's what we want to do. Do we want to look at the mental healthcare delivery system in the State of Connecticut and try and make recommendations on how to modify that, which that's a big -- I mean, that is a huge task. And if we do, then I would suggest we pick some part of it. I think if we, for example, try and figure out the financing of it, that's -- that's a -- that may be insurmountable for this group to do in a year.

So maybe it's not the financing. It's looking at the types of programs that we think need to be there. But if we're now going up into adulthood, then, you know, if you do up to 25 or 27, and said are we going to then look at young adults? And what about the elderly and what -- You know,

it's not that it's -- it's not good or bad. It's just you can have mission creep, and then you can just take on so much. And so all of the speakers that you have talked about, all of the topics I think are quite appropriate. But as we listen to them, it would help me if I knew, okay, so you're talking about 25-year-olds? The reason this is relevant to me right now is I want to figure out how this helps kids in schools. If -- Or am I listening to it because I'm now trying to think about how to improve the mental health of 25-year-olds or am I trying to think about the treatment of 25-year-olds with mental illness? Or am I trying to figure out the systems that would be cost-effective to provide that treatment? And I guess that's -- So that's where -- It's not that the topics aren't great. It's just I would be helped if I knew where am I -- Why -- What am I listening to this for? What's my filter? So that I can hone in on actionable items for recommendations.

SPEAKER: The reason that we had talked about the full spectrum of age was really to address the charge of the governor to be looking at mental health within the state. Certainly this commission can decide to focus more in certain areas

than the other. We've got a semi-permeable boundary between a child who's three years old who acts out and a six-year-old and a nine-year-old and so on. And we have many people in the state who are adults with mental illness or we might say people with mental health issues for whom the current service delivery system isn't working.

This may give us an opportunity to say if we were building it again recommending going forward, this is what we would need to put in its place. So there's really no one right way to do it. I do agree we need to focus, but having a broad array of ideas certainly will help us to focus.

SCOTT JACKSON: And to that point, critical to that process, that semi-permeable boundary is creating an articulation point between the youth system and the adult system, so we do not hit one of those transitions that Ms. Keavney was talking about, where you go off your trajectory and there's no one there to see it so that hand-off is coordinated in a more significant fashion.

SPEAKER: Very briefly, this is a bit like renovating an old house. The roof leaks, so you want to fix it. And the plumbing leaks, you can't take a shower, you want to fix it. The floor

is creaking, you're going to fall through it. We have this wonderful saying in the design profession, scope and creep. And I know for me personally -- and I don't know whether this is shared -- as I listen to these, I'm very much sensitive to what David said which was, I can be a much more effective commission member if I know where I want to go, what questions I want to ask, based on the deliverable we want to produce. And so maybe as a suggestion at the end of the sessions, I know we don't all want to stay here until midnight on Friday night, but if we can revisit this issue of deliverable of what we want at the end of each one of these sessions, I need a scope creep; I need to be bracketed. I know that I'm -- I'm not struggling, but I know I'm not being as effective as I could be. So if we could, Chair, think about at the end of each one of these sessions, are we closer to understanding what we think we want to produce as a deliverable at the end of each one? Because then I can focus more intelligently on what the presentations are, ask relevant questions about that knowing that those questions are focused on what it is that we as a commission group think we want to produce. That's just a suggestion. I don't know how others feel

about that.

KATHLEEN FLAHERTY: I just wanted to let people know for those people that might not be aware of this, and this might affect how people think about this, that in the new law that the governor signed last week, there actually is a new task force established. So folks may know or may not know, but they have a very specific mission, and that's why I was flipping through this because I wanted to find it. But they have a task force to study the provision of behavioral health services in the state with a particular focus on the provision of behavioral health services for persons 16 to 25, inclusive. And they have to analyze and make recommendations concerning improving behavioral health screening, early intervention treatment, closing gaps in insurance coverage, case management, insufficient number of certain behavioral health providers and 13 other things. So I'm not going to read them all. But basically folks should know it's Section 66 of the new law. So that might be something for us to consider too when we look at what we want to focus on in our report.

SPEAKER: I think you hit it right on the head, and I wonder if we would think about

mental hygiene, you know, the old turn of the century sort of term, but I think that that's what you were sort of suggesting, the idea of, you know, good health from a mental perspective. So thank you.

SPEAKER: You know, I liked the way we did the feedback with the whole gun thing and the safety, we sort of fed it to you, and you called out the things that were common, and we discussed it. Perhaps that's a way to go, too, with some of these issues around mental health and behavioral. Excuse me. If people submitted to you like a draft of a mission statement and, you know, submit -- Maybe not you, maybe you're too busy, but to one central person, and then we could sort of consolidate views like that, and then we'd have some food for thought to take away or to study in the days between the meetings.

SPEAKER: So I find myself really of many different minds about this. I think this is -- you know, it's going to be difficult for us to formulate exactly how we proceed, you know, forward.

As I think about the notion of mental hygiene, it gets back to, you know, the distinction between mental health and mental illness, often used

kind of interchangeably, and yet if you think about mission creep, you know, to my mind it lies on the mental health side or the mental hygiene side, which -- you know, which can reach to, you know, all of the things that could lead and contribute to a healthy and productive life. And really, you know, it is potentially endless.

When I think about what do the people of Connecticut want from us, I think what they want is something that dresses what looks to them like mental illness and its ramifications and consequences and what the interventions are around mental illness that we would recommend. And then I started making notes. Before you read about the legislative paneling notes, well, you know detection, and that goes to schools and what we can do in schools, access to care and then -- and effective programs, things that will change lives, the lives that are coming up and perhaps reduce the risk of future events because that -- you know, that it might connect to reducing the risk of future events I think will always be on people's minds, and they'll always want to see some tie-back to that. We know the tie-back to it. Any tie-back we come up with will be very vague and generalized.

But then, as I think about detection and access effectiveness of programs, I'm thinking well, that's what the legislative panel is going to be doing. And I'm wondering should we have some contact with the people who are setting up the legislative panel and try to draw some differentiation between how they're seeing their task and how we're seeing ours?

You know, as far as I'm concerned, we got started on this commission just at the time that the legislature came together and formed their big bipartisan panel with four subpanels, and if it was -- you know, there may have been some discussion between us and them, but if there was, I'm not, you know, aware of it. And they went ahead and made a whole bunch of recommendations which they have enacted, which it kind of looked like were within the purview of our charge, and now we're at risk for having that very same thing happen again. There are two panels. One's appointed by the governor, we call it a commission. Another's being appointed, probably as we speak, by the legislature; they're calling it a task force, actually. And it -- would it help to try to clarify the distinction between our two groups and our missions?

SCOTT JACKSON: Do you have a response?

SPEAKER: Just a little behind the scenes. Because we had decided very definitively that we were going to focus on guns and school safety issues in our preliminary report that we issued in formal form on the 18th of March, I did speak to legislative staffers to say that we weren't ready with mental health related recommendations because we were asked directly on behalf of the -- or I was asked directly on behalf of this commission if we had recommendations and the legislature would have been willing to entertain them. So I think that's very positive, and maybe at this point looking at these recommendations, we could engage with the parties that are organizing that particular task force to make sure that if we're heading in the same direction or mutually complimentary directions, we take advantage of that role.

SPEAKER: I'm just trying out an idea and option for people to consider since I was not aware of this group being formed and I do see that the mission would overlap, potentially quite significantly or ought to, to be quite honest. So one option would be to say, look, our group was

created in response to an episode, it was formed quickly because there was a sense of a need for urgency, which was quite appropriate. Subsequently, another group is now being formed to study this more in depth, so what we could do is help frame the questions that this group would then answer in moving forward.

And so we could say that these in our deliberations, either based on our reflection of what has occurred in school crisis events, which is one narrow area of how mental illness or mental health impacts the lives of children, but -- or we can certainly broaden it as to say these are the issues that we think are there so beyond what's in the bill, but actually now say through our testimony, through deliberations and through our discussion, we've identified these areas in a little more depth than we would specifically like this group or another -- but I think it's then presumed it's them -- to go in more depth, and then they'd have a starting point. But I agree we would want to reach out to them and talk with them, and make sure that they felt comfortable with us playing that role, because if they say no, we want to set our own agenda, then that wouldn't be a good use of our

time.

So that's one option we could do, and then we could focus more on an area that's, you know, more specifically related to schools so -- and I've already voiced this to a couple people -- is that I think I understand the issue around the gun safety, and I think it is important for us to make those recommendations in a timely way. We're now looking at mental health, but we have not really looked at the mental health of children that are impacted by crisis events. And we're called the Sandy Hook Commission for a reason, and I really feel like we're not talking about what they need.

And I'm not suggesting that we would give specific recommendations to that community, because I don't think that's our place. But there are children who are impacted by crisis events in schools, and they don't have mental illness, and they're not the ones with the guns, but that's what we're named after. So I think to a certain degree I'd like to speak to the issue that's facing communities such as that that will be helpful to that community now if they choose to review that information, and it will be unfortunately helpful to other communities. And whether or not it's from a

shooting in their school or whether it's from community violence in their communities, I think there are a number of children that would benefit from some careful deliberation and consideration of how to be helpful to that group. And I -- So I don't see it just as guns and mental illness. I see it as those impacted by the intersection of this.

SPEAKER: I just want to get -- So if I'm understanding it -- So the -- Because I know we have the session that's scheduled on the trauma interventions, but this is trauma above and beyond for people that are already in care for mental health issues. This is dealing with trauma that's faced by the community in general, specifically the kids who were in a school after some kind of traumatic event.

SPEAKER: And what I will say is that there is -- And I don't know the speakers that are coming, but I would imagine that you're going to be hearing a talk about trauma symptoms and trauma disorders. Kids that are in schools that have been in events such as this are also dealing with grief and bereavement. They're also dealing with senses of difficulty with safety, anxiety, sadness, depression. How do you support staff that are in

that situation? How do you prepare teachers to be able to be supportive to children who are dealing with those range of issues?

And I'm concerned that we may be focusing just on one type of mental illness or adjustment problem that is very real and very pressing and needs to be addressed. So I don't in any way want to diminish that, but you know, I'll give you an example: When I went out to Aurora a couple weeks after the shooting, I was talking with one of the victims in their home, and he had -- the person on either side of him was shot and killed, and he was unable to kind of -- He wasn't coming into work, and people were concerned about him, and he had not gone in for any counseling. And so when we went to his home to talk to him, he was saying that, you know, he did have some trauma symptoms. He had some difficulty sleeping, but he said it happened in the dark; he got pulled out before he even knew what was going on; he had discussed those issues. His sleep has improved; he's been talking with his peers who were in the movie theater, and so I don't really want to go for counseling, but I'm just not feeling right yet.

And then I spoke with him about the fact

that one of the people killed was a very close friend that he had grown up with, and I said, "Do you think perhaps it might be an issue that your friend is dead?" And he said, "That's what it is." And I said, "Would you like to talk to someone about that?" And he said, "If you have someone for that, I will go. But I don't want to go for trauma treatment."

Now, the concern was that several weeks had passed, but no one had offered that to him. And I've been in a number of communities. I've worked with New York City after 9/11. New York City didn't even have a bereavement center for children. And so -- And they have one now, but it's small and it's struggling. And so the issue is bereavement treatment isn't reimbursable in the same way as trauma treatment is.

And there's all of these issues and so -- And it tends to crowd out some of the other concerns that children have. So, definitely, we do need to discuss trauma. But I think we need to broaden the conversation beyond that, and I don't know that we have that planned to do. So yes, children in Sandy Hook went through a horrible tragedy and a lot of trauma, but they also lost

peers. And so I want to make sure we broaden the conversation a little bit, and I don't know that we're doing that yet.

SPEAKER: I know that some of that was covered way back when, when Dr. Wong came in from UCLA with her charts, and we should probably go back and look at that presentation. I know in an ideal world, after listening intently today that, you know, if we sat down for an omission statement or we'd probably start by drawing some different charts with how you would gain access to the system.

I mean, as I hear this over and over and over again, there are so many needs. And the theme I keep hearing is there are so many barriers to meeting those needs in this system. So when I think of a report, I think of whether we're talking about accessibility to care and insurance or the students who have been traumatized by the incident. Gaps in coverage, we have for acute, we have for outpatient, but there's a whole set of needs that aren't being met. I just think how do we set up a system that we tear down those walls? How do we -- Every time we come across that, just say this is what would be appropriate or more appropriate because it doesn't sounds like overall the system works in a myriad of

ways, and there's so many people I respect immensely in this room. There's got to be some better ways. There's got to, because so many of us are working so hard to meet those needs, but they're not being met well.

SPEAKER: And I just want to clarify because there's two sets of needs there, the kind of perennial needs of mental health (unintelligible) in communities, and then there are also the acute, and they become long-term needs of the communities that have gone through catastrophic events. And so I just want to make sure: There are barriers to getting mental health treatment in Connecticut as there are in every other state in the country. There are a unique set of needs and I would argue a unique set of potential solutions to the barriers for communities that have been directly impacted by events, but what happens is there's the presumption that those needs get taken care of by other mechanisms, and those -- When you go through these events, you realize those mechanisms are not as effective as you would like in terms of efficiently and comprehensively meeting the needs of the children and the staff, and so I'm just asking, Ron, if that's -- if that's an area that we want to

go into, which is a school has an event, how do we as a state respond to those needs so that you aren't relying solely on donated services, local resources or federal resources that may or may not be delivered in a timely way and meet all the needs? So if -- Do you want our group to also address that?

RON CHIVINSKI: Absolutely. I don't think there's anything we should shy away from. I know that -- remembering when Dr. Wong was here, and she was showing a lot of long-term graphs of the peaks and the valleys and the highs and the lows that both students and staff and community members would go through, and a little bit of no-man's land, I would argue right now with our long-term recovery plan. You know, and I know a lot of staff are, you know, outside of Sandy Hook Elementary School itself a little bit anxious. I think the theme of -- You're right. There are many different types of needs, and that's what I keep hearing, many different types of needs. And there is a Sandy Hook in the Sandy Hook Advisory Commission, and I think that we have an obligation to look at those specialized needs for all those involved and how well or how well not they're met and how best you do meet them.

I know specifically that our union, you know, from the national on down, has invited Neosh (Phonetic) in to really try to analyze this. So the answer to your question would be yes.

SPEAKER: I think it is a good thing to remember our name, Sandy Hook Advisory Commission, and that we, I think by the nature of that and when and how we were established, need to address -- in addition to anything else we may wish to address -- those matters that are specific to this particular incident. And that would include -- I think that has to include the special needs of communities who have been traumatized by events like this and how a state like Connecticut might organize itself to respond in the future.

There are other specifics which we really haven't started to get to, so we have not yet had the report from the state's attorney, and I don't know if we had it if it would have provided enough information to know, but at some point we will know whether the shooter in this case, in fact, was someone on the autism spectrum. And hopefully we will know whether, over the course of his life, there were difficulties in accessing resources and other things necessary to address the problems that

he might have had.

Now, I know we've had some discussion in the past that the advocates for individuals on the autism spectrum would rather that we not have a discussion about that. But, in fact, when we talk about access, access to care for individuals who are on the autism spectrum is a very big problem, perhaps bigger than access to care for individuals who have schizophrenia. So if it does turn out when final reports are issued, you know, about this event and, you know, we learn more that this may have been the case and -- for this individual and that issues of accessing care played a prominent role in his and his mother's life, I think it would -- it will turn out to have been a mistake if we do not look at the issue of access to care for that group of individuals.

ALICE M. FORRESTER: I also -- In what Dr. Schonfeld said around, you know, sort of the particular incident, am interested, also, in perhaps hearing from the families from Newtown. I don't know if there's been any conversation around having them available to be on the agenda or if they have been invited to speak. I have personally interfaced with quite a few of the members, and they

have a lot to say on some of the hygiene and mental health conversations that we're having and -- in terms of response, and I think that it would be helpful to have their voice and/or, you know, invited, if that's something that we can do.

SPEAKER: Just to piggyback on Alice's comment, I think if we're going to move in the direction of this kind of acute response as well as in a long-term response in looking at what works, what doesn't, what needs to happen when another tragedy, God forbid, happens, we need to give a voice to the people who are in it. We need to hear from the teachers, and we need to hear from administrators, and we need to hear from families.

That's a big charge, though. And that's a very big ask. And I think if this group commits to doing or moving in that direction, then those are the people we can't forget about, the Newtown community, the leaders there. But I also think that timing is certainly a challenge right now because Newtown is in the thick of it. The families are in the thick of it, the teachers are, and so to Dr. Schonfeld's point about kind of having this commission put together perhaps not a template, but a plan for the future, we don't know what the

lessons learned are from Newtown yet.

And so I would just caution us to take that into consideration. But, again, I would endorse inviting the Newtown community, the families, the teachers to share their experience, what their lessons have been and how their stories can shape what we recommend.

ROBERT DUCIBELLA: I'll be quick. Just, as we think about how broad our task is ultimately, just an advisory that we should keep our eye on the issue of commission fatigue. I don't say that as a warning that we should do less because we might become fatigued, but rather that at particular points as we contemplate, you know, where we're going to go, that there could be a little fatigue that can set in that could perhaps lead us to lower our expectations of ourselves, and that would be a mistake.

SPEAKER: I just want to say thank you to Kathy for drawing our attention to this document because I think that it's important reading as we set the agenda and some of what we think our goals are moving forward, because in this, including what you referred to, there is also threat assessment and stigma and other issue that have been

addressed in the law. So I think that we need to understand that and either add emphasis to it or take it off our list. But I think that there is quite a bit in there that we have talked about certainly today that we ought to be mindful that has been addressed in the legislation, and we need to decide how to deal with it now that it has been included in the bill. Thank you.

SPEAKER: I'm thinking of Alfred Hitchcock. Alfred Hitchcock frequently used advice known as the "Macguffin," which is when you think the movie's about one thing and it turns out to be about another thing. We have been mistakenly called the gun panel. I think the guns were the Macguffin here. As we move forward on this topic, I'm calling the Macguffin out and say that I was mistaken. I think that Dr. Schwartz is exactly right in how he framed what I think the residents of Connecticut expect from this commission in terms of mental and behavioral issues, and that is that intervention point, creating the intervention point for someone who is on a bad trajectory. However, as we keep talking about it, it appears, while there are certainly financial and provider issues in terms of access, it seems that this issue of stigma, if it's

not at the top of the list, if it's not item number 1, it's item number 1 prime, and dealing with that issue is not one of mental illness, but one of mental health. So like Mr. Lyddy, who acknowledged that his thoughts on things changed as the panel's progressed, so have mine. I came in thinking of mental illness, and now I'm thinking of mental health.

So what I'm going to try to do is take these items that have come up, and if people have other thoughts upon reflexion -- you know, we all have a drive home somewhere, if you have other thoughts and you want to shoot me some thoughts by email, I'd be glad to accept them. We'll try to synthesize that into a document of some sort that provides at least the first cut of a framework so that we can then sort of mark our progress, as Mr. Ducibella said, and then make sure that, well, we always maintain the flexibility, then we'll have the direction. We will always maintain that flexibility, but focusing our efforts may be useful at this point. So I will try to put that together. Any other remarks? Dr. Bentman?

ADRIENNE L. BENTMAN: Yeah. It's not a remark. It's actually just -- It's a really

more concrete framework question. We're in the middle of April, and so now would be a good marker point to look at the Fridays from now through May and sort of tell if there are Fridays we know we're going to be meeting, when are they? If there are Fridays we know we're not going to be meeting, when are they? And --

SCOTT JACKSON: -- keeping the calendar. I think the working group had every Friday in April from here out scheduled, right?

SPEAKER: I think so. There's two-and-a-half more dates of testimony that we have currently scheduled.

ADRIENNE L. BENTMAN: That's April. How about May?

SPEAKER: Yeah, I think the first -- I think we have something, I know, for the morning of May 3rd. I think we have that half day, and it's just a matter of scheduling that second half of May 3rd.

SCOTT JACKSON: We will provide an updated schedule with the meeting notice for next Friday. Mr. Chivinski?

RON CHIVINSKI: Thank you. Harry, if you can find that article you referenced, that

would be great if you could send it out.

HAROLD SCHWARTZ: I definitely could find it, and I will -- I'll get it out to the commission.

SCOTT JACKSON: Seeing nothing else, thanks for your time, everyone. Thanks for your attention and we will see you, or at least most of you, next week. Take care.

(Hearing concluded.)

CERTIFICATION

I hereby certify that the foregoing 71 pages are a complete and accurate transcription to the best of my ability of the electronic sound recording of the April 12, 2013, Sandy Hook Advisory Commission hearing.

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Chloe M. Stefanelli, LSR Date