STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

A HEALTHCARE SERVICE AGENCY

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Testimony of Thomas A. Kirk, Jr., Ph.D., Commissioner Department of Mental Health & Addiction Services Before the Public Health Committee February 21, 2007

Good morning, Senator Handley, Representative Sayers, and distinguished members of the Public Health Committee. I am Dr. Thomas A. Kirk, Commissioner of the Department of Mental Health and Addiction Services, and I am here today to speak on four bills that are before the committee — (1) **S.B. 1066, An Act Concerning the Department of Mental Health and Addiction Services;** (2) **S.B. 696, An Act Expanding the Jurisdiction of the Department of Mental Health and Addiction Services;** (3) **S.B. 666, An Act Concerning Safe Residential Treatment Facilities for Effective Recovery;** and (4) **H.B.7104, An Act Establishing a Mental Health First Aid Pilot Program.**

Let me preface my testimony by thanking the committee for your assistance in raising S.B. 1066 and S.B. 1068, which were part of the DMHAS legislative package. Following the conclusion of my testimony, Dr. Michael Norko, the Director of the Whiting Forensic Division of Connecticut Valley Hospital, will speak in support of **S.B. 1068, An Act Concerning Patient Rights at Whiting Forensic Division.**

1. I will begin my remarks by speaking strongly in favor of **S.B. 1066, An Act Concerning the Department of Mental Health and Addiction Services.** S.B.1066 makes a series of technical and other changes to our statutes, as follows:

The first section will now require that individuals in our inpatient settings who may get served legal papers actually receive the papers. The current statute only requires that these be given to the director of the facility where they reside. We believe that the individual who is in our care should have the right to receive these papers as well. We would continue to require that the facility director be copied on such service, but it is fitting—in a recovery-oriented system of care— that we recognize the rights of the individual who is served with legal papers and ensure that he or she receives copies of such documents.

Sections 2, 13 and other sections would eliminate statutes that refer to the former Fairfield Hills Hospital and the former Norwich Hospital, which no longer exist.

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Section 3 and other sections would replace the words "substance abuse disability" with the wording currently used by the federal government and other states, i.e., "substance use disorders." The word "abuse" places blame on the individual, i.e., "substance abuser," whereas the latter wording is reflective of current thinking in the treatment field and is more recovery friendly.

Section 20 would allow DMHAS to produce a single Affirmative Action plan for the agency, as is current practice for the Departments of Mental Retardation, Correction, and Children and Families — agencies with structures similar to DMHAS, in that they have multiple facilities located throughout the state, but which are not required to write Affirmative Action plans for each facility.

- DMHAS has taken important steps in recent years to consolidate its operations, including a centralized Human Resources Division (which includes Labor Relations, Employment Services, Payroll and Benefits, and Information Systems); thus, all hiring and recruitment for the entire agency statewide is done through a single location.
- As a federal contractor, DMHAS is required by the Office of Civil Rights to have a single Affirmative Action Plan on file for the whole agency. Having a similar arrangement at the state level would conserve agency resources and allow our Affirmative Action officers to spend more time implementing our Affirmative Action program.
- A single, combined plan would eliminate certain current practices that may "skew" Affirmative Action results — such as having to count employee transfers from one DMHAS facility to another as "meeting hiring or promotional goals" for the recipient facility or, that under the present system, there is nowhere to record when a DMHAS employee accepts a promotion to a different DMHAS facility. Such a change would allow DMHAS to more accurately reflect its efforts to affirmatively address agency hiring and promotional goals.
- It would also reduce the workload and paperwork for both DMHAS and CHRO, as well as the need to keep referring back to the individual plans in order to determine the agency's overall progress in meeting its goals.
- Lastly, streamlining the present process would be far more cost effective and would better conserve needed resources at a time when all state agencies are being asked to review their operations for ways to reduce costs.

We understand that the Commission on Human Rights and Opportunities has some concerns about this proposed change to a single plan, and we would welcome the opportunity to work with them to ensure a smooth transition.

Section 21 proposes the elimination of statutes which reference agency facilities that no longer exist, including Special Act 91-11 that applied only to mental health providers, capping the amount of money that could be allocated from a DMHAS grant for the salary of an executive director at $75,000. This language was enacted during the 1991 fiscal crisis and, because it applies only to mental health providers (not substance abuse ones), this results in unequal treatment among our provider agencies.

We would also propose eliminating Sec. 17a-711, a statute that would have had us create a task force on substance abusing pregnant women and their children. This committee was never appointed, but in the meantime we have made real progress toward addressing the needs of women with substance use disorders. We have launched a three-year initiative to ensure that our system of

care is responsive and accessible to women. Working with other state agencies, providers, trade associations, and consumers, DMHAS created the **Women's Services Practice Improvement Collaborative** (WSPIC), which is designed to enhance Connecticut's behavioral health system for women in ways that are trauma-informed, gender-specific, and that promote self-determination. The level of enthusiasm, support, and dedication nurtured by the initiative has gratified participants. As a result, DMHAS has become a **nationally recognized leader** in gender-responsive programming. DMHAS funds Women's Recovery Specialists (including peer support specialists) who are now providing case management to women transitioning from residential care back into the community. The Judicial Branch's Court Support Services Division (CSSD) is now using the DMHAS Gender Responsive Treatment Guidelines.

Lastly, we would eliminate a statute that duplicates CGS 17a-453c, referring to our collaboration with DCF in Project Safe. Since 1995, Project SAFE has offered priority access to substance abuse evaluations, drug screens, and outpatient treatment services to primary caregivers of children involved in DCF child protective service cases. A centralized intake service implemented by Advanced Behavioral Health (ABH), a private non-profit, managed behavioral health organization, has facilitated these services through contracts with DCF and DMHAS. ABH provides network management services for a large group of providers, also under contract with DMHAS to serve these clients.

2. With regard to **S.B. 696, An Act Expanding the Jurisdiction of the Department of Mental Health and Addiction Services,** while we deeply appreciate the confidence that Sen. Harp and others have in our current service system, we cannot support the proposed transfer of 16- and 17-year-olds with behavioral health needs from the DCF system to DMHAS at this time.

Let me assure you that I believe that Connecticut— as well as other states facing similar problems with this age group— must pay greater attention to adolescents in need of behavioral health services, but there is no way that DMHAS could take on this new population without a significant infusion of new resources. We would need to develop an entirely new infrastructure across the state to serve this population of adolescents who have very significant, age-specific needs. We would have to hire, train and closely supervise a workforce that, frankly, does not exist at this time and which would require specialized skills to work with this age group. We would need to establish and maintain separate (at least one, if not more) inpatient units because one cannot treat adolescents on the same unit as adults (defined as 18 and older). The same would be true for any residential or 24-hour treatment setting. An adolescent population cannot safely be mixed with an adult population. In addition, many of our current providers are stretched to the limit and would tell you that they do not have sufficient resources now to deal with the populations we currently serve, much less could they take on such additional responsibilities at this time.

We are still in the process of ramping up our service system to meet the demands of the 18- to 21-year-olds we already serve who are aging out of the DCF system and need behavioral health services from DMHAS. Regardless of the closeness in age, we cannot simply "mix" the 16- and

17-year-olds in with the young adults, because there are significant developmental differences between the two groups. Giving us this additional population group would not serve the 16- and 17-year-olds well, and it could negatively impact services to the other groups DMHAS is already serving. For the foregoing reasons, we are unable to support S.B. 696.

3. With regard to **S.B. 666, An Act Concerning Safe Residential Treatment Facilities for Effective Recovery,** DMHAS has some concerns regarding the bill's intent and would like to work with you to resolve whatever problems exist for communities that offer housing alternatives to people in recovery from substance use disorders.

At the outset, I should clarify that the language in **S.B. 666** refers to "residential treatment facilities." The sober congregate living houses to which DMHAS provides support are not licensed residential treatment facilities, but rather are a safe, sober, supportive and affordable environment where recovering people reside while they engage in treatment off-site, attend peer-run meetings, and transition back to work.

That distinction having been made, it should be noted that research has proven that housing, jobs and relationships are the keys by which persons with substance use disorders can recover and become productive members of society. We know that peer support can keep a person from relapsing during the recovery process. Sober houses provide that much needed support to individuals in our system in measurable ways.

Perhaps a brief history would be helpful. In 1997 the General Assembly transferred responsibility to DMHAS for managing state-administered General Assistance (SAGA) behavioral health benefits. In 1998, a fund was created for DMHAS to pay for basic needs—such as housing, clothing and transportation—for individuals who are seeking or engaged in treatment. Previously, such monies were given to individuals with behavioral health needs for them to spend as they saw fit. Legislators at that time wanted to change that practice, so they created the Basic Needs Program. A large percentage of this program's funding pays for housing—specifically, "sober" or peer-run housing— which offers not only a roof over someone's head, but also ongoing support, house rules and AA meetings, and relationships, that research has shown time and time again help an individual to sustain his or her recovery.

Our goal is to provide those living in state-funded sober houses with safe housing. We recognize the delicate balance between the need of a city or town to ensure that houses are compliant with local zoning laws and the need of individuals in recovery to have such housing available. To that end, we have developed a certification process to ensure that local zoning laws are followed. We believe that this process will assure that the sober houses to which DMHAS provides support have heat, hot water and electricity, and that the homes do not exceed the capacity set by local zoning ordinances.

DMHAS works closely with Connecticut Community for Addiction Recovery (CCAR), a statewide advocacy organization that has made impressive inroads in helping those with substance use disorders to make a successful transition to recovery. We are also in the process of setting up meetings with officials in both Norwich and Preston, who have expressed concerns about this type of housing in their towns, and it is our intention to work with them regarding their concerns. As the committee weighs these issues, it is important to note that such housing is a linchpin in the recovery process, because it provides structure for the residents and requires that they participate in activities that assist them on the road to recovery. Society as a whole benefits when individuals are able to reclaim their lives and become productive, contributing members.

If the goal of the local zoning boards and this committee is to ensure that individuals residing in their towns live in safe houses, rest assured that DMHAS has the same exact goal, and we will continue to work diligently toward that goal. If the committee deems that we need to change our process to accommodate community concerns, then please allow us the opportunity to work with you to do that.

4. The fourth bill on which I will comment today —**H.B. 7104, An Act Establishing a Mental Health First Aid Pilot Program** —is an interesting concept, but we believe that DMHAS has a plan to implement such a program that is broader than H.B. 7104 and is tied to a federal grant we received, called the Mental Health Transformation Grant.

In October 2005, Connecticut was awarded a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for the purpose of transforming the state system of mental health care for all citizens of Connecticut. The work being done on transformation involves not only the Department of Mental Health and Addiction Services, but 13 other state agencies and the Judicial Branch, as well as consumers and family members, state and private providers, and other key stakeholders.

Based on the President's New Freedom Commission Goals (and an additional goal focusing on workforce transformation), work groups have been developing recommendations that have become part of Connecticut's Comprehensive Mental Health Plan. This Comprehensive Mental Health Plan will drive the transformation process across the state over the next four years to establish a statewide, recovery-oriented system of care and services. The system will cross the lifespan (from birth onward) and will also cut across state agencies and the private sector. The goals are laudable and address many of the issues raised in H.B. 7104. This grant is worth $13.7 million over five years and is available for training, workforce development, and other infrastructure changes necessary to make Connecticut a national leader in transforming the entire mental health system.

The initial steps for this transformation include the following:

- Prevent suicide and increase mental health awareness through health education in schools.

- Give individuals and families a voice regarding mental health services through a universal feedback tool.
- Identify and eliminate mental health disparities through standardized data collection.
- Expand access to prevention, screening, early intervention and treatment by maximizing state and federal dollars.
- Prevent youth from becoming involved in, or having repeated involvement with, the juvenile justice system through the use of evidence-based practices.
- Provide Connecticut citizens with a first-of-its-kind, comprehensive mental health website to improve access to mental health information and resources.
- Expand and enhance mental health training throughout Connecticut's workforce.
- Enhance and protect the rights of individuals with mental illness.

We believe that we can incorporate the language contained in H.B. 7104 into the plan that we will present to the federal government in connection with the roll-out of the $13.7 million Mental Health Transformation Grant. We would be happy to work with the Public Health Committee and keep you updated on our progress with regard to this grant.

In closing, let me add that it is my sincere belief that the end product of this grant will achieve not only the outcomes articulated in H.B. 7104, but also a much better system for the delivery of mental health services in Connecticut.

Thank you for allowing me to speak on these four bills. I would be happy to take any questions you may have at this time.