



National Alliance on Mental Illness

5416  
6415

**Testimony before the Human Services Committee**  
**February 24, 2009**  
**Support for HB 5416 and HB 6415**

Good morning, Senator Doyle, Representative Walker, and members of the Human Services Committee. My name is Alicia Woodsby, and I am the Public Policy Director for the National Alliance on Mental Illness, CT (NAMI-CT). I am here today to testify in support of **HB 5416** (An Act Concerning the Transition of Care and Treatment of Children and Youth from the Department of Children and Families to the Department of Mental Health and Addiction Services) and **HB 6415** (An Act Establishing a Pilot Program for the Department of Children and Families to Place Abused and Neglected Children in the Care of Families rather than Institutions).

HB 5416 will codify and expand upon the Memorandum of Understanding (MOU) between DCF and DMHAS, so that the agencies may be held accountable for failing to follow the established interagency agreements for the adequate transitioning of youth with mental health needs. It will ensure early identification of transitioning youth, appropriate transition planning, and adequate follow up and monitoring. It will also establish clear timelines. Without clear timelines and without transparency, many youth with serious mental health needs continue to fall through the cracks. Despite the current MOU, many youth are still not referred to the DMHAS in a timely fashion, and even when transition plan are developed -- they are often poorly implemented or not implemented at all.

This bill also has the potential to change and improve practice by requiring both DCF and DMHAS to report annually to the legislature regarding the plan for transitioning youth from DCF to DMHAS and to provide information on outcomes and barriers.

For now, many young adults are falling victim to the gaps between the two systems—often resulting in their becoming homeless, incarcerated, dependent upon emergency care, and altogether abandoned by systems mandated to care for their welfare. This places our communities at risk at a much higher cost to the state. We are encouraged by the reporting standards included in HB 5416, and want to reinforce the absolute necessity of requiring DCF to report on the factors influencing what should be a continuum of care during the transition of vulnerable youth into the adult system. The behavioral health of this age group is the focus of national attention. We must have an understanding of their diagnostic profiles, service outcomes, gaps in services and treatment options, as well as the availability of qualified staff. This bill will help determine the barriers to timely referral, transition, and receipt of services.

HB 5416 also calls for the development of a pilot program for youth and young adults with the most intensive mental health needs who require age-appropriate housing and services allowing them to transition between both DCF and DMHAS without mandated changes in their housing or services.

We desperately need collaborative programming between DCF and DMHAS to ensure that 16-17 years olds are not forced to leave a stable home and service environment when they turn 18. The number of referrals of young adults from DCF to DMHAS central office continues to rise dramatically, with an increase of more than 4500% since 1998. Many of these young people have intensive service needs related to both their psychiatric conditions and years of institutionalization with minimal preparation for adulthood. The failure with these youngsters is lack of any continuity in their lives, no trusting relationship with an adult through adolescence into adulthood, and denial of opportunities to continue with their developmental tasks as other young people can.

DCF further illustrates the need for this pilot in their budget option priority number 8 (attached), which proposes a residential pilot program to meet this exact need. DCF notes a number of young adults in care with mental health needs who are older and waiting for the transition to DMHAS adult services. As a result of inappropriate treatment options and waiting lists, many of "these young adults may end up staying longer than needed in expensive residential levels of care"

We believe that this bill is urgently necessary, and long overdue, to ensure that young adults with serious mental illnesses "aging out" of DCF care will be connected with services and treatment from DMHAS, and that the state track outcomes in the current service system to establish a clear understanding of the population and their needs.

In addition, NAMI-CT supports HB 6415, which establishes a pilot program that places children in DCF care in family settings with qualified foster parents or relative caregivers, rather than in expensive institutions. The pilot program allows for children already in institutional settings to be transferred into family settings, and requires DCF to submit a report concerning the results of the pilot to the appropriate legislative committees. The lack of an appropriate and accessible continuum of community based options for kids has resulted in significant numbers of children utilizing inpatient and residential services and being sent out of state. The state has close to 75 beds at Riverview at \$2,369 per person per day or \$864,685 per year, and a cost of \$1,214 per person per day or \$443,110 per year for residential beds at High Meadows Residential Treatment Center. The state also has 104 beds at Cedarcrest, many of them filled with young people who have come from DCF and have no community housing or programming to which they can be discharged, which cost \$1,179 per person per day or \$430,335 per year.

NAMI-CT urges the state to spend DCF money differently and more productively through specialized service options that wraparound the child and the family and are based on individual need. We continually hear stories of children who are placed in a particular service type or level of care because it was the only slot available, and not because it is actually what the child needs. This is often detrimental to the child's well-being at a high cost to the state.

Thank you for the opportunity to speak with you today. I would be happy to answer any questions.

**2009/2010-2010/2011 Budget Options**

Expansion Option

DCF91000 - Department of Children and Families Contact: Greg Messner  
 11000 - General Fund Telephone: (860)550-6617

Priority: 8  
 11/10/2008

**Establish Transitional Youth Program**

**DESCRIPTION & REASON**

DCF has a significant number of young adults in care with mental health needs who are older and waiting for transition to DMHAS adult services. Most of these youth cannot transition to DMHAS for at least 1-3 years because of waiting lists, transition periods extending 9-12 months, or the need for levels of care that are not available at DMHAS. As a result, these adults may end up staying longer than needed in expensive residential levels of care (as of today, LINK reports 177 young adults over 18 in intensive placements such as RTC and TGH). Some young adults choose not to wait and refuse both DCF and DMHAS services. DCF cannot place 18+ year olds in DCF facilities; there is no emergency placement capacity within DCF or DMHAS and very limited respite capacity in DMHAS. Unfortunately this often results in homelessness, arrests, hospitalization, ER visits, or return to the families from which they were removed. DCF policy then prohibits their re-entry into care because of their mental health issues and lack of stability.

The Department proposes to address the gap between when youth are leaving DCF and when they are entering in DMHAS by developing three 8-bed transition programs for a total capacity of 24 beds across the state and 3 respite programs for a total capacity of 18 beds across the state. The target population is youth with major mental illnesses and/or trauma histories, who are either currently eligible and waiting to transition to DMHAS or are waiting for a determination of DMHAS eligibility.

The Department proposes additional funding to support the development of one transitional program and one respite program during FY 2010 at a cost of \$955,000, and the remaining 2 transitional and 2 respite programs in FY 2011 at a combined FY 2011 cost of \$4,087,500.

**MEASURE OF IMPACT**

Has the agency thoroughly researched the possibility of federal funds to support No

**Current status**

Agency has applied for and received grant award No  
 Agency is in the process of applying for grant No  
 Federal Funds are available for this program No

**Explanation of status**

No Explanation

Code / Title	2008 Actual	2009 Estimated	2010 Base	2010 Option	2010 Revised	2011 Base	2011 Option	2011 Revised
43168 - Behavioral Health Out of Home Services								
16138 - Board and Care for Children	191,692,099	219,683,378	215,254,751	955,000	216,209,751	220,722,974	4,087,500	224,810,474
Option Total	191,692,099	219,683,378	215,254,751	955,000	216,209,751	220,722,974	4,087,500	224,810,474
Quantifiable Statistics	2008 Actual	2009 Estimated	2010 Base	2010 Option	2010 Revised	2011 Base	2011 Option	2011 Revised