



STATE OF CONNECTICUT

5416

DEPARTMENT OF MENTAL HEALTH
AND ADDICTION SERVICES
A HEALTHCARE SERVICE AGENCY

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GOVERNOR

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Testimony of Pat Rehmer, M.S.N., Deputy Commissioner Department of Mental Health and Addiction Services Before the Human Services Committee February 24, 2008

Good morning, Sen. Doyle, Rep. Walker and distinguished members of the Human Services Committee. I am Deputy Commissioner Pat Rehmer of the Department of Mental Health and Addiction Services, and I am here today to speak on **H.B. 5416, An Act Concerning the Transitioning of Youth from the Care of the Department of Children and Families to the Department of Mental Health and Addiction Services.**

Connecticut began providing services to young adults who were aging out of the DCF system in 2000—both as a matter of agency policy and also because it became apparent that many of these young people were leaving DCF without being systematically referred to DMHAS for their ongoing treatment needs. DMHAS began its collaboration with DCF and started the program with a very small number of individuals who had significant service needs. This program—known as Young Adult Services or YAS—has become the major driver in the DMHAS budget, and the individuals we are now seeing have extraordinarily complicated lives. The number of young adults requiring our services has increased over 1000-fold since the program's inception, and their needs are much more complex than those of the older adults whom we currently serve.

We have reviewed H.B. 5416 and, while we appreciate and admire its intent, we have some major concerns that we need to share with you for your consideration.

First, H.B. 5416 would require DMHAS and DCF to schedule a transition planning meeting within 30 days of determining eligibility for our Young Adult Services program. Currently, individuals are referred between their 16th and 18th birthdays. It is often necessary to prioritize older "young adults," because they will enter the DMHAS system of care earlier than those who are just turning 16. While it is important to begin transition planning as early as possible, the number of young adults being referred to us makes it difficult to begin transition planning for all of them within 30 days of their referral. An alternative proposal would take into account that the 30-day interval specified in the proposed bill is an arbitrary number, the intent of which is to ensure that transition planning is undertaken in a timely manner. We suggest, as replacement language, that ***"within 14 days of eligibility an 'urgency of transition priority rating' be given to each eligible client and agreed upon by both DCF and DMHAS."*** This change would permit necessary flexibility in the scheduling of the initial transition planning meeting, based upon clinical need and practical time frames.

At present we receive approximately 30-40 referrals from DCF each month, and we are barely keeping up with that number with our existing staff. In the event we are required by law to schedule the transition planning at the time of referral, we could not meet this mandate with existing staff resources. Such a change would require several additional clinical staff in order to complete the evaluations and participate in the required transition planning meeting.

Secondly, this legislation would have us begin services to youth before they turn 18. Providing increased continuity of care during this difficult transition period is long overdue and, if implemented wisely, can only benefit these young people whose needs are so complex and so pressing. However, DMHAS does not currently have the statutory authority to serve individuals under the age of 18. DCF and DMHAS would have to collaborate on developing both a model of services and a cadre of staff having the training and skill sets appropriate to the developmental span being targeted. It cannot be overemphasized that sufficient resources would have to be allocated to fund this project if the plan is to have a reasonable prospect of success. The competencies required for clinicians treating adolescents differ considerably from those required for clinicians treating young adults. We are currently struggling to meet the needs of the increasing population of 18- to 24-year-olds entering our system and would need an infusion of resources to serve this new group of younger individuals who have very different service needs.

Parts 2 and 3 of Section 3 of the bill raise additional fiscal and logistical issues for DMHAS. Calling for the development of a transition plan for DMHAS services when an individual is 14 years of age, we believe, is premature and something for which we do not have the expertise. Further, we question the predictive validity and reliability of accurately making such clinical and diagnostic judgments. At minimum, to attempt such a level of refinement would require highly sophisticated data collection and monitoring for which we do not have the staff or other infrastructure resources. In addition, Section 3 requires that annual reports be made to the Community Mental Health Strategy Board, which is proposed for elimination in the Governor's budget.

Once again, I must emphasize the pressures we are experiencing to promptly review referrals stemming from current demands for those aged 18 to 24.

Lastly, Section 4 of the bill creates a pilot program for 16- to 18-year-olds that is not currently funded and cannot be managed "utilizing existing funds" as stated in the bill. Present resources are barely sufficient to provide the various levels of care needed by the youth already being referred to us. The additional dollars appropriated to us in the Governor's proposed budget will enable us to provide the levels of care required for the population of 18- to 24-year-olds we currently treat and those of that age group who continue to enter our system in increasing numbers.

We also believe that the proposed pilot program would require us to explore regulatory changes in regard to funding streams, entitlements, legal issues, guardianship issues, supervisory issues, agency policies and procedures, etc. Beyond the funding issues, implementation of this

program would require additional staff that is highly trained in working with younger populations, as well as imposing new data requirements on the agency that we are not equipped to meet.

At present, the Young Adult Services program is stretched for resources. It has grown considerably over the last 8 years, and we expect that expansion to continue as larger numbers of troubled young adults enter our system. Specifically the YAS budget has grown from \$5,379,810 in FY 2000 to \$39,673,367 in FY2009, an increase of 637%. Estimates for new cases from DCF in FY10 and FY11 are for 185 young adults to enter our system each year. There are no indications that the rate of referrals from DCF will ebb at any point in the foreseeable future.

Those young adults currently in or projected to enter our system are individuals who have very complicated treatment needs. They are not our traditional clients, and we are still learning every day about the new challenges they pose and the resources required to meet their service needs. To add yet another population at this time with unique and challenging requirements which we lack the funding, staffing or expertise to adequately address could adversely impact service delivery to the other populations we already serve. For the foregoing reasons, we are unable to support this bill.

Thank you for the opportunity to address the Committee today on H.B. 5416. I would be happy to answer any questions you may have at this time.