



# STATE OF CONNECTICUT

## DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

*A HEALTHCARE SERVICE AGENCY*

M. JODI RELL  
GOVERNOR

THOMAS A. KIRK, JR., Ph.D.  
COMMISSIONER

### Testimony of Thomas A. Kirk, Jr., Ph.D., Commissioner Department of Mental Health and Addiction Services Before the Public Health Committee March 6, 2009

Good morning, Sen. Harris, Rep. Ritter and distinguished members of the Public Health Committee. I am Dr. Thomas A. Kirk, Jr., Commissioner of the health care agency known as the Department of Mental Health and Addiction Services, and I am here today to speak in favor of **S.B. 847, An Act Implementing the Governor's Recommendations Concerning Public Health**, Sections 51 through 67 of which impact DMHAS.

This bill would make a number of changes to the statutes, such as:

- a. Enabling us to consolidate our services at Cedarcrest Hospital into Connecticut Valley Hospital;
- b. Updating the Pretrial Alcohol Education and Pretrial Drug Education programs to bring them into uniformity;
- c. Eliminating all references in statute to the Community Mental Health Strategic Investment Board;
- d. Funding our tobacco enforcement positions out of the Drug Forfeiture Account for the next biennium, which is something the General Assembly has already approved in the recent deficit reduction plan; and
- e. Giving us the ability to bill Medicare for certain hospital patients' prescriptions.

All of the foregoing are proposals that would implement the Governor's budget.

- Under **Section 51 of S.B. 847**, DMHAS would be allowed to recoup federal dollars under Medicare Part D for medications prescribed to individuals in our state hospitals. There are some administrative issues that need to be worked through, but if this change is approved, we hope to reduce our state expenditures for these medications, where applicable, and maximize federal reimbursement.
- **Section 52** would transfer to the Drug Forfeiture Account the cost of our tobacco enforcement positions. These are the young adults we hire to conduct compliance checks in order to ensure that retailers are not selling tobacco to minors. The legislature approved a similar proposal in the last deficit mitigation bill, and this language would allow us to continue to use the Drug Forfeiture Account for these positions.

- **Sections 53, 54, 55, 64, 65, and 66** take out all statutory references to the Community Mental Health Strategy Board. The Governor has proposed to take the remaining funding in the budget sweeps proposed in her budget; therefore, the board will have no remaining need and is being proposed for elimination.
- **Sections 56, 57, 58 and 59** make a number of changes to the Pretrial Alcohol Education Program and the Pretrial Drug Education Program to achieve uniformity of their missions, standardize their fees and make other changes that fit into a “best practices model” of treatment.
- **Section 56** would tighten up the current use of the Pretrial Alcohol Education Program, re-establish the program’s credibility, and better focus any supplemental intervention on the individual needs of the offender. Use of this program is a privilege, not a right. Offenders agree up front to cooperate with the program, but once admitted to the program, we have found that some individuals’ commitment begins to wane. Providers do not “violate” participants without cause and without first attempting to resolve issues. However, the “word on the street” is that participants don’t have to comply with the program rules and requirements, because there are few adverse consequences for non-compliance, and reinstatements have become more routine, instead of the exception. The end result is that some individuals are reinstated 4, 5, and even 6 times, and it is not uncommon for such reinstatements to span two or more years after the offense. Multiple reinstatements strain the service delivery system and result in higher costs for the courts, the service providers, and the department.

We address some of these issues by instituting fees for reinstatement. The identified fees are lower than those for the initial program; thus, they should be more manageable for participants to meet, even for those who were previously determined to be indigent. Allowing an individual a maximum of two reinstatements still gives an offender “three bites of the apple” and does not remove all judicial discretion. This is not a “one-size-fits-all” approach. Persons returned to court as “program failures” are assessed as to their most current needs; then, if eligible and reinstated, they can be placed in a service level better able to address their individual needs.

- **Section 57** would allow for the expansion of services to eligible offenders under the Pretrial Drug Education Program, thus mirroring the opportunities available to DUI offenders through the Pretrial Alcohol Education Program. These include a more comprehensive evaluation of each offender, yielding an individualized recommendation to the court as to the most appropriate level of services. Placement in either one of two intervention levels (Level 1: 10-weeks -15-hours; Level 2: 15-weeks – 22.5-hours) or treatment is dependant upon professional assessment and judicial decision. These options would replace the current eight-week, 12-hour intervention group, and tie services to offender needs in order to achieve “more bang for the buck.” It would also grant courts the discretion to refer underage drinkers into the program, thus permitting a professional evaluation of such youthful offenders and providing the opportunity to intervene with them at an earlier age than is currently possible. It is our understanding that the Judicial Branch may need some changes to these proposals to make them more workable and that they will testify as to what changes they believe are necessary.

- **Section 58** makes some technical changes to the name of the Pretrial account, allows for the fees generated to be deposited into this account, and permits DMHAS to spend up to \$500,000 on prevention programs if the account has extra money in it to do so.
- **Section 59** also contains technical changes to the pretrial statutes.
- **Sections 61 and 62** allow DMHAS to make necessary physical changes to the CVH campus in order to relocate approximately 63 beds there from Cedarcrest Hospital in Newington. This would result in a single state hospital administration and one hospital campus. We used a similar statutory model when we consolidated Norwich Hospital and Fairfield Hills Hospital into CVH.
- **Sections 63 through 66** would eliminate all references in statute to the Community Mental Health Strategy Board.
- Parts of **Section 67** would eliminate references in statute to Cedarcrest Hospital, the Community Mental Health Strategic Investment Fund, and the Community Mental Health Strategy Board.

Thank you for the opportunity to address the Committee today on S.B. 847. I would be happy to take any questions you may have at this time.