NEIL ABERCROMBIE
GOVERNOR OF HAWAII

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In reply, please refer to:
File:

House Committee on Health

H.B. 649, Relating to Health

Testimony of Loretta J. Fuddy, A.C.S.W., M.P.H.
Director of Health

Wednesday, February 13, 2013, 8:30 a.m.

Department's Position: The Department of Health (DOH) respectfully opposes the bill, while supporting the intent of restoring and revitalizing the mental health service system.

Purpose and Justification: The department of health appreciates the intention of the legislature to expand mental health services. During the economic crisis of 2008-2010, it is acknowledged that the amount and types of mental health services provided by the department were restricted. While painful, those restrictions were considered temporarily necessary to survive the economic downturn. Core services were preserved, although on a smaller scale, so that those most in need continued to receive service through the worst days of the recession. Since 2011, services have been expanded and plans are now being formulated, with significant community input, to further restore services and revitalize the mental health system going forward. In 2012, crisis and case management services were expanded, and at this time a statewide series of community forums are being held to provide input to the department as we determine which services to prioritize next for restoration and revitalization.

The department does not support the specific contents of the first part of the bill, especially the provision which defines by statute eligibility for services restricted to the diagnoses listed and limiting the department's ability to make rules to implement the statute. Our concerns are that to define

eligibility in statute and limit the ability of the department to make rules, which results in the loss of administrative flexibility necessary to respond to any changing economic environment or individualized needs specific to a local or regional community. Specification of eligibility in statute curtails the operational flexibility needed to administer departmental operations.

The department is committed to the revitalization of our mental health service system, as we have expanded services in the last twelve months, and plan to expand more in the near future. Plans include allowing eligibility for additional diagnoses and services, based on input from the community as we plan for service delivery in the coming year.

The rulemaking process allows for community input, and the department believes that is an appropriate mechanism by which to operationalize the scope and array of services offered, rather than through statutory change. Rulemaking allows for the flexibility needed to expand or modify the service array based on the external realities which may come (such as the Affordable Care Act, Department of Human Service health plan changes, or clinical changes such as those to be included in the new Diagnostic and Statistical Manual, 5th edition, which will be released in 2013).

The department appreciates the legislature's intent by adding appropriations for both restorations of mental health services and services for the homeless population. Depending on the extent and scope of future changes to eligibility criteria and services restored, additional budgetary resources, if needed, will be requested of the legislature in future sessions.

Thank you for the opportunity to testify.

HAWAII SUBSTANCE ABUSE COALITION

HB649 Mental Health: AMHD: Homeless Services: Appropriates funds for substance abuse treatment and mental health support services for individuals who are homeless or at risk of becoming homeless.

- HOUSE COMMITTEE ON HEALTH: Representative Au Bellati, Chair; Representative Morikawa, Vice Chair
- Wednesday, Feb. 13, 2013; 8:30 p.m.
- Conference Room 329

HAWAII SUBSTANCE ABUSE COALITION Supports HB649 with recommendations.

GOOD MORNING CHAIR AU BELLATI, VICE CHAIR MORIKAWA, AND DISTINGUISHED COMMITTEE MEMBERS. My name is Alan Johnson. I am the current chair of the Hawaii Substance Abuse Coalition (HSAC), a statewide hui of more than twenty non-profit treatment and prevention agencies.

RECOMMENDATIONS:

Recommended changes are underlined.

SECTION 3. Section 334-3, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows: "(c) The department shall specifically:

(6) Establish standards and rules for services in the areas of mental health and substance abuse treatment, <u>which core services are based upon evidenced-based practices for substance use disorder treatment</u>, including assurances of the provision of minimum levels of accessible service to persons of all ages, ethnic groups, and geographical areas in the State;

BACKGROUND

Patients who have both a drug use disorder and another mental illness often exhibit symptoms that are more persistent, severe, and resistant to treatment compared with patients who have either disorder alone.

Integrated co-occurring disorder treatment includes the National Institute of Drug Abuse's extensive university level studies with over 40 years to define evidenced-based practices (EBP) for these modalities:

- **residential,**
- **intensive outpatient**
- **outpatient**
- **ACT teams.**

Examples of Behavioral Therapies for Patients with Comorbid Conditions

Multisystemic Therapy that targets key factors with serious antisocial behavior in those who abuse drugs. **Brief Strategic Family Therapy** that targets family interactions involved with drug abuse and other co-occurring problem behaviors.

Cognitive-Behavioral Therapy (CBT) modifies harmful beliefs and maladaptive behaviors. CBT is also effective for populations suffering from drug use disorders and a range of other psychiatric problems. **Therapeutic Communities (TCs)** focus on the "resocialization" of the individual and use broad-based community programs as active components of treatment. TCs are particularly well suited to deal with criminal justice inmates, individuals with vocational deficits, women who need special protections from harsh social environments, vulnerable or neglected youth, and homeless individuals.

Assertive Community Treatment (ACT) programs integrate the behavioral treatment of other severe mental disorders, such as schizophrenia, and co-occurring substance use disorders. **Dialectical Behavior Therapy (DBT)** is designed specifically to reduce self-harm behaviors (such as self-mutilation and suicidal attempts, thoughts, or urges) and drug abuse. **Exposure Therapy** is a behavioral treatment for some anxiety disorders (phobias, PTSD) that desensitize patients to the triggering stimuli and helps them learn to cope, eventually reducing or even eliminating symptoms. Several studies suggest that exposure therapy may be helpful for individuals with comorbid PTSD and cocaine addiction. **Integrated Group Therapy (IGT)** is a new treatment developed specifically for patients with bipolar disorder and drug addiction, designed to address both problems simultaneously.

Effective medications exist for treating opioid, alcohol, and nicotine addiction and for alleviating the symptoms of many other mental disorders, yet most have not been well studied in comorbid populations. Some medications may benefit multiple problems.

We appreciate the opportunity to provide testimony and are available for questions.

HAWAII DISABILITY RIGHTS CENTER

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THE HOUSE OF REPRPESENTATIVES
THE TWENTY-SEVENTH LEGISLATURE
REGULAR SESSION OF 2013

Committee on Health
Testimony in Support of H.B. 649
Relating To Health
Wednesday, February 13, 2013, 8:30 A.M.
Conference Room 329

Chair Belatti and Members of the Committee:

The Hawaii Disability Rights Center is in strong support of this bill, which restores a wide range of mental health diagnoses as qualifying for eligibility for AMHD services.

Our agency has had a lot of concerns regarding changes in services and programs of the Adult Mental Health Division over the past several years. There has been reduction after reduction in services provided to individuals with mental illnesses. That included the elimination of services such as the ACT teams and the drastic reduction in the number of case management hours. In the larger picture, it is clear to us that ever since the Department of Health was deemed to be relieved from the provisions of the Consent Decree in the case brought by the Department of Justice, (USA v. State of Hawaii, Civil No. 91-00137) there has been a constant "backsliding" in the effort by the state to comply with the terms of the Decree.

In many respects, the final blow, so to speak, occurred in July, 2009, when the Department of Health unilaterally eliminated several psychiatric diagnoses as qualifying for eligibility for services. These diagnoses had been developed as part of the consent decree and were an Attachment to the Plan for Community Mental Health. As a result of the Department's internal action, diagnoses of anxiety disorders and personality disorders were eliminated as diagnoses which qualify an individual to receive AMHD services. This has resulted in some seriously mentally ill individuals not being able to obtain any assistance for their mental health needs.

It is an artificial distinction to say that only those individuals with what the Department terms a "Serious and Persistent Mental Illness" (SPMI) diagnosis should receive help, while all others are excluded. This narrow universe effectively excludes many individuals who may REALLY need services that can be provided by AMHD. This is not just the receipt of psychiatric care, but all the attendant services that come as a benefit to being eligible for AMHD. This would include case management; the supported housing opportunities, such as independent apartments or group homes; and admission to the clubhouse program. All these benefits are available only to those in the AMHD system. This bill will statutorily supersede the administrative rules and open up eligibility to many individuals who need, but are not receiving, services. To the extent that additional resources may need to be allocated to the Department, we very much support the provision in the bill which adds an appropriation clause for that purpose.

We also support the provision which addresses an anomalous situation currently created by AMHD and their new rules. In addition to the restrictive list of diagnoses, an individual is not eligible for AMHD services if they have any insurance. On the surface this may seem reasonable and when it was first presented to the public it appeared to makes sense, inasmuch as if someone has private insurance which can pay for their medical or psychiatric needs, the state should certainly be the payer of last resort. We support that very much. However, while private insurance or even QUEST or Quest Expanded Access may cover the cost of psychiatric care, frequently those policies do not cover the other services offered by AMHD. This rule results in an arbitrary, irrational situation whereby an individual who otherwise has a severe and persistent mental illness will not receive any services from the adult mental health division (such as case management, clubhouse or supported housing) simply because they happen to have private insurance, notwithstanding the fact that the private insurance they possess does not cover those services they may be seeking.

A vivid example is the clubhouse program, which happens to be one of the most economical of all services provided. In addition to being very cost effective, it also provides what may be the only socialization that some mental health consumers ever receive. It is a lifeline and a portal to the rest of the world. It is also a program that is rarely, if ever, covered by private insurance. So, this means that someone could have a very serious persistent mental illness and even have one of the very serious, restrictive diagnoses now required for eligibility and yet not be able to attend the clubhouse because they also have private insurance. We have specific clients in that situation. The mere possession of private insurance will automatically disqualify the individual for any AMHD eligibility. The fact that the insurance does not cover the clubhouse or any other ancillary AMHD services is irrelevant under the current AMHD rules. It is an automatic disqualification, regardless of whether it covers the service the individual is seeking.This is absurd, and without any logical basis. For that reason, the essence of the language in the bill is to continue the practice that the state will be the payer of last resort, but to provide that if someone otherwise has a qualifying diagnosis, they are eligible to receive services provided by AMHD that are not otherwise covered by any insurance policy held by them or on their behalf.

While the Department of Health has not revisited this policy and opened up AMHD eligibility to a larger, more inclusive group of individuals, we do note that the Department of Human Services has proposed to amend its Medicaid waiver to make some of these ancillary services part of the covered behavioral health benefits. However, as we understand the current proposal of the Department of Human Services, eligibility is just slightly more open than the current AMHD rules. The Department still would not include any anxiety or personality disorders as qualifying for services. Most notably omitted is PTSD. While these individuals can still receive psychiatric care, they would not be eligible to receive the waiver services that are being proposed in the Department's amendments.

We understand that individuals who formerly were treated within the AMHD system have been transferred to the Department of Human Services and that there are pending plans for transfers of larger numbers of individuals. We believe many of them are currently in the Medicaid Quest Expanded Access Plan. If in fact that occurs and AMHD is then servicing a much smaller group of individuals, then the focus of this bill may be more appropriately addressed to the Department of Human Services. We suggest that the Legislature attempt to get clarity from the two departments as to what exactly the plan is and when it is expected to occur. We would then hope that the resources would be allocated to the appropriate Department who could then implement the expanded eligibility created by this bill.

It is our hope that this session, the Legislature will take action as may be appropriate to ensure that the mental health consumers of our state receive the appropriate care and treatment to which they are legally entitled. This bill will go a long way towards restoring services for many of these individuals and we strongly urge the legislature to support this effort.

Thank you for the opportunity to testify in support of this measure.