An Evaluation of the Delivery of Mental Hygiene Services in New York State

A Report by the Mental Hygiene Task Force to Assemblyman Peter M. Rivera Chair of the New York State Assembly Standing Committee on Mental Health, Mental Retardation and Developmental Disabilities

February 2005

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February 2005

Honorable Sheldon Silver
Speaker
New York State Assembly

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Dear Mr. Speaker:

Almost 15 months ago, I convened a statewide mental hygiene work group to help chart a new direction for New York's crisis plagued mental health system. The Mental Hygiene Task Force of the New York State Assembly Mental Health Committee is composed of key policy and decision makers representing mental health advocates, consumers of mental health services, heads of county agencies, hospital administrators, leaders of the nonprofit service delivery sector, representatives of the state workforce and other interested individuals.

Today, months of meetings, conference calls, research and a busy traveling schedule by the dedicated group of volunteers that comprise the Task Force allows me the opportunity to present to you an important report that, in its pages, holds endless opportunities for improving New York's Mental Hygiene System. This report also signifies a clear acknowledgement that our present system of delivering mental health services to our fellow citizens is in disarray, needs reform and must be strengthened to meet the desperate demand for help.

This report begins the work of setting a new direction for the state's network of services for the mentally ill, while targeting key areas for immediate action that will lead to a more efficient and effective delivery of services to a growing population with mental health needs. A clear message is being presented here, one that places the consumer of mental health services at the center of proposed changes to the government bureaucracies that have been built to serve our mentally ill.

The recommendations outlined in this report are important first steps in rebuilding a system that many feel has lost focus of its humanitarian mission. While not every recommendation reached a consensus of agreement of the Task Force members, most did and all are presented here for further review, input and further action.

There are areas of critical importance, some of which are in crisis, that were not addressed in this report, but will be examined in future reports and in the course of the work of the Mental Health Committee. These areas included an examination of the mental health problems facing the prison population, the young men and women in juvenile detention centers, the children in our foster care system, and the ongoing crisis in New York's adult homes.

It has been 25 years since New York's Mental Hygiene system was last reorganized. Today we have a system that is inefficient, fragmented and expensive to operate, while many who are in need of services go without access or attention.

The Mental Hygiene Task Force focused on improving the organization of the Office of Mental Health to better meet the needs of the mentally disabled. The Task Force also proposes restructuring the mental health service delivery system, with particular sensitivities to regional variances and improving utilization of existing fiscal, human and organizational resources. This is a daunting yet exciting challenge that will require sincere government commitment and diligence.

I am looking forward to working with the mental health community to help prioritize the most pressing issues facing the sector. Working together, and with your ongoing and steadfast support of the important work of the Assembly's Mental Health Committee, I have no doubt that we will begin to see substantial improvements in charting a new direction for our mental health delivery system this year.

Sincerely,

Peter M. Rivera
Chairman

The Mental Hygiene Task Force of the New York State Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities

Members:

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Committee on Underserved Populations
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Committee on Resources
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A Report from the Mental Hygiene Task Force to Assemblyman Peter M. Rivera, Chair of the Committee on Mental Health, Mental Retardation and Developmental Disabilities:

An Evaluation of the Delivery of Mental Hygiene Services in New York State

I. EXECUTIVE SUMMARY

In February 2001, the New York State Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities initiated a comprehensive review of the status of the mental health service delivery system. It was apparent that the mental health system was not designed to allow for the recovery of persons with mental illnesses. On October 31, 2002 the Committee issued a report entitled, ***Broken Promises, Broken Lives: A Report on the Status of the Mental Health Delivery System in New York State***. The report concluded that the current system of service delivery was not meeting the needs of the citizens of the State. As a result, thousands of mentally ill persons have suffered indignities and abuse, and hundreds of others have succumbed to untimely deaths due to a dysfunctional mental health system.

In response to the issues identified in the Committee's 2002 report, the Committee formed a Mental Hygiene Task Force in November 2003 to make recommendations on restructuring the mental hygiene service delivery system. The Task Force was comprised of over fifty members representing consumers, families, advocates, service providers, unions and local government officials. The Task Force determined there was a need to expand on the initial recommendations of the 2002 Committee report.

Four committees were formed to respond to various issues:

- Committee on Intergovernmental and Strategic Planning;
- Committee on Continuum of Services;
- Committee on Underserved Populations; and,
- Committee on Resources

The Committee on Intergovernmental and Strategic Planning focused on the structural issues of the mental hygiene system that hindered the development and implementation of a comprehensive system of services. The Committee on Continuum of Services focused on the service delivery constructs that need to be addressed in order to better serve the needs of the mentally disabled in a consumer and family centered system. The Committee on Underserved Populations focused on identifying those populations of the State that are in need of both service and care, their respective unmet needs, and the service barriers that hinder development and provision of appropriate services to these populations. The Committee on Resources focused on the availability and constructs of resources, public and private, which impact on the service delivery systems for the mentally disabled, and how to better utilize such resources.

These Committees of the Task Force met regularly during 2004, developing recommendations and action steps to restructure the mental hygiene service delivery system to better meet the needs of the mentally

disabled. The Committees identified a number of themes, based on their differing perspectives, which have guided the development of this report.

Themes:

- The system is fragmented resulting in the inefficient use of scarce public resources. This fragmentation leads to a failure to provide the kinds of integrated services people with mental disabilities need.
- The process of planning and service delivery must be open and public, and must be strengthened to incorporate all stakeholders, including consumers, families, providers and local and state governments.
- There is a need to improve bottom up, data-driven, needs based planning that is transparent, consumer and family focused, and outcome driven, and that accurately communicates the needs of the State as a whole and the various regions and counties within the State.
- Services to the mentally disabled cross system lines and often require joint planning. These systems include, but are not limited to, education, child welfare, juvenile justice, health, housing, employment, temporary services, and corrections.
- There is a need to coordinate and integrate service delivery at the local government and the programmatic level.
- There is a need to simplify funding streams and enhance flexible use of funding.
- There needs to be a transitional system that meets the needs of a person through his/her life span.
- The system needs to be person centered, based upon choice and satisfaction, and outcome driven.
- The system needs to be culturally and linguistically competent.
- The system needs to encourage creative and flexible solutions that meet the needs of individuals and that fit the context of the local services system.
- A future orientation is necessary to move beyond traditional structures and methodologies that hinder evolution to a more modern and responsive system of care to better meet the current and future demands for service.

Each Committee of the Mental Hygiene Task Force made several recommendations to restructure and improve the mental hygiene system in New York State. This interim report is intended to guide the public discourse that will lead to an effective, efficient consumer and family focused system of service delivery. The Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities will hold a series of public hearings across the State to obtain public input regarding the recommendations contained herein and will issue a final report with legislative proposals in the fall of 2005.

II. INTRODUCTION

The people of the State of New York have historically supported policies designed to improve the lives of persons suffering from mental disabilities. The State Constitution, the Mental Hygiene Law and related statutes provide expression to that support and form a framework for the development and implementation of an effective system of service delivery.

A. NEW YORK STATE CONSTITUTION

ARTICLE IV, SECTION 3: The governor shall. . . .expedite all such measures as may be resolved upon by the legislature, and shall take care that the laws are faithfully executed.

ARTICLE XVII, SECTION 4: The care and treatment of persons suffering from mental disorder or defect and the protection of the mental health of the inhabitants of the state may be provided by state and local authorities and in such manner as the legislature may from time to time determine (approved by a vote of the people November 8, 1938).

B. MENTAL HYGIENE LAW

In the preamble to Chapter 978 of the Laws of 1977, which created the Department of Mental Hygiene, the Legislature found that:

> "Protecting the mental health of the people of the state, preventing the occurrence of mental illness, mental retardation and developmental disabilities, alcoholism and substance abuse and assuring that state residents afflicted by such disabilities receive appropriate care and treatment are matters of public concern.
>
> "It is the policy of the state of New York that all of its residents who are disabled will receive services according to their individualized needs and, whenever possible, in their home communities to enable them to realize their fullest potential for self-fulfillment and independence in society.
>
> "In order to facilitate the implementation of this policy, the legislature finds and declares that the provision and regulation of services to the separate classes of the mentally disabled can be most effectively and economically carried out by three independent offices. . .The establishment of separate offices as proposed by this act is designed to provide the governmental framework within which available resources will be more effectively brought to bear in providing care and treatment to the different classes of disabled persons. . .This division of responsibilities is intended to lead to efficiencies in administration and shall in no way diminish the commitment of the state to maintain the highest quality of patient care both in facility and community-based programs providing an appropriate variety of treatment alternatives."

III. HISTORY

For the first fifty years of the State's history, local governments and private agencies were responsible for the care of New York State's mentally ill. In 1836 (Chapter 82), the Legislature authorized the construction of the State's first mental health institution, the State Lunatic Asylum in Utica, which opened in 1843. By 1890, the State had opened nine additional asylums for the mentally ill. Local governments were responsible for expenses of inmates at these asylums and many local governments also continued to confine the mentally ill in jails and poorhouses. In 1867 (Chapter 951), the Legislature established the Board of State Commissioners of Public Charities to inspect and report to the Legislature on all publicly funded charitable and custodial institutions. Legislation in 1873 (Chapter 571) replaced this board with a new State Board of Charities, mandated licensing of public and private institutions for the mentally ill, and created the Office of State Commissioner in Lunacy. This commissioner's office was abolished in 1889 (Chapter 283) and replaced by an independent State Commission in Lunacy consisting of three gubernatorial appointees.

The Commission was empowered to license, regulate and investigate public and private institutions providing care for the State's mentally ill; to maintain a record of judges and medical examiners legally qualified to order commitments; and to register all the insane in custodial care. The 1894 State Constitution subsequently transferred the responsibility for inspecting mental institutions from the State Board of Charities to this Commission.

In 1890 (Chapter 126), the State took on the entire responsibility for the care of New York State's mentally ill. The State thereby began providing for the care of all indigent mentally ill persons at state expense in state institutions and prohibited their confinement in jails and poorhouses. In 1912 (Chapter 121), the Commission was renamed the State Hospital Commission and was given responsibility for the administration of the

State's mental hospitals. In 1918 (Chapter 197), state supervision of care for the mentally handicapped was further centralized with the creation of the State Commission on the Feeble-Minded. Renamed the State Commission for Mental Defectives in 1919 (Chapter 633), it supervised the care of "mentally defective" persons at five state special-care institutions.

A Department of Mental Hygiene (DMH) was established in 1926 (Chapter 584) as part of the 1925-26 constitutional reorganization of state government. The new Department assumed all the functions of the State Hospital Commission and the State Commission for Mental Defectives, which were abolished. A Division of Mental Disease was assigned the oversight of state hospitals for the mentally ill.

Although the organization of the Department remained essentially the same until 1966, changes in the 1950s began a shift to a decentralized approach to care for the mentally ill. In 1954 (Chapter 10), the Legislature established community mental health boards and provided for partial state funding of local mental health services. The federal Community Mental Health Act of 1963 provided additional funding for community mental health centers, and further state legislation strengthened the role of local governments and community-based services in New York State throughout the 1970s. As a result of decentralization, patient population in state mental institutions declined over 60% from 1958 to 1975.

During this same period, state programs began reflecting the growing societal awareness of the problems caused by alcoholism and drug abuse. In 1966 (Chapter 192), the Narcotic Addiction Control Commission was created within the Department to supervise the operation of alcohol and narcotics-addiction treatment centers and to coordinate community rehabilitation and prevention programs. In 1973 (Chapter 676), this Commission was renamed the Drug Abuse Control Commission and two years later (Laws of 1975, Chapter 667) the Commission was replaced by the Office of Drug Abuse Services.

In January 1972, a documentary by television news journalist, Geraldo Rivera, revealed deplorable living conditions at the Willowbrook State School on Staten Island. Subsequently, parents of 5,000 persons living at Willowbrook State School filed suit over the inhumane conditions at the facility. On May 5, 1975, the Willowbrook Consent Decree was signed, committing New York to improving community placement for the "Willowbrook Class." Parents of mentally retarded and developmentally disabled persons pressured the Governor and Legislature to establish an independent agency, which would be responsible for their children. Special interests representing persons suffering from alcoholism were also demanding their own independent state agency that would be responsive to their needs.

The previous administrative structure of the DMH was heavily weighted in favor of mental health programs. It was difficult for programs in mental retardation and alcoholism/substance abuse to receive proper attention. In addition, the previous department structure continued to emphasize institutional care of the mentally ill and was unable to effectively support the growth of needed community care.

Chapter 978 of the Laws of 1977, divided the DMH into three autonomous agencies: the Office of Mental Health (OMH), the Office of Mental Retardation and Developmental Disabilities (OMRDD), and the Office of Alcoholism and Substance Abuse (comprised of two autonomous divisions: the Division of Alcoholism and Alcohol Abuse and the Division of Substance Abuse Services). In 1992 (Chapter 223), the Division of Alcoholism and Alcohol Abuse and the Division of Substance Abuse Services were consolidated into one Office of Alcoholism and Substance Abuse Services (OASAS).

Chapter 978 of the Laws of 1977 also established an Inter-Office Coordinating Council (IOCC), consisting of the Commissioners of each of the Offices within DMH. The IOCC was empowered with the responsibility to:

> ". . .ensure that the state policy for the prevention, care, treatment and rehabilitation of mental illness, mental retardation and developmental disability, alcoholism, alcohol abuse, substance abuse, substance dependence, and chemical dependence is planned, developed and implemented comprehensively; that gaps in services to the multiply disabled are eliminated and that no person is denied treatment and services because he suffers from more than one disability; that

> procedures for the regulation of programs which offer care and treatment for more than one class of mentally disabled persons be coordinated between the Offices having jurisdiction over such programs; and that research projects of the institutes are coordinated to maximize the success and cost effectiveness of such projects and eliminate wasteful duplication. . ."

The Legislature provided the IOCC with resources to carry out its mandate. The research institutes within the DMH were placed under the IOCC. Certain computerized functions were also placed within the IOCC to ensure coordination of planning and service delivery between the Offices. Over time, under pressure from the Commissioners of each of the Offices within DMH, all functions previously assigned to the IOCC were transferred to the Offices and the IOCC was stripped of its resources. The IOCC had been effectively eliminated as the coordinating body within the DMH.

This led to a fragmentation of the planning, development and implementation of services for the mentally disabled. Gaps in services for the multiply disabled were created as each Office proceeded to develop its own regulations and funding mechanisms independently of one another.

In addition, Chapter 655 of the Laws of 1977 created the Commission on Quality of Care for the Mentally Disabled (CQC). The CQC was established as an independent agency within the Executive branch of government to carry out oversight and review of mental hygiene programs and facilities as specified by law. The Legislature intended the CQC to provide an independent analysis of the functioning of the Offices within DMH to facilitate improvements in service delivery to the mentally disabled. Consequently, Section 45.07 of the MHL gave the CQC certain functions, powers and duties, including the authority to:

> (a) Review the organization and operations of the Department of Mental Hygiene, to advise and assist the Governor in developing policies, plans and programs for improving the administration of mental hygiene facilities and the delivery of services therein, and to ensure the quality of care provided to the mentally disabled in the State is of a uniformly high standard.
>
> (b) Review the cost effect of mental hygiene programs and procedures provided for by law with particular attention to efficiency, effectiveness and economy in the management, supervision and delivery of such programs. Such review may include, but is not limited to: (i) determining reasons for rising costs and possible means of controlling them; (ii) analyzing and comparing expenditures in mental hygiene to determine the factors associated with variations in costs; and (iii) analyzing and comparing achievements in selected samples to determine the factors associated with variations in program success and their relationship to mental hygiene costs.

The CQC, whether due to a lack of resources or of Executive support, has not used these powers to analyze the organization and operations of DMH nor has it completed reviews of the cost effectiveness, supervision and delivery of mental hygiene programs to the extent intended by the Legislature. The legislative intent to utilize the CQC to help foster an efficient, effective, accessible, accountable, coordinated and integrated mental hygiene service delivery system has not been fully realized.

The continued lack of integration led former Governor Mario Cuomo to convene a Select Commission in 1984 to review the efficacy of the State's mental health system. The Governor delegated the Commission a threefold charge:

1. Recommend a restructuring of mental health services to better meet the needs of the mentally ill and those at risk of mental disability;

2. Develop improved mechanisms of financing mental health services; and,

3. Redefine the functions of state and local governments to improve the types of services provided, and their delivery and coordination.

While the Select Commission's report focused on the mental health system, many of the issues identified by the Select Commission continue to impact the mental hygiene service delivery system twenty years later. Planning continues to be budget driven with little relationship to local needs and resources. A lack of coordination and integration of services between the Offices within DMH and other human service agencies has resulted in a fragmented system of service delivery which, too often, ignores all of the needs of mentally disabled individuals, fosters gaps in services to the multiply disabled and underserved populations, limits access to appropriate services, and results in a lack of accountability in outcomes for both the service delivery system and the individuals being served. *(See Appendix for additional information regarding the Commission's findings and recommendations.)*

IV. THE SUBCOMMITTEES

A. INTERGOVERNMENTAL AND STRATEGIC PLANNING

Planning

In 2001, the Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities and Committee on Alcoholism and Drug Abuse began a review of agency compliance with the planning and reporting requirements of the Mental Hygiene Law (MHL). It quickly became clear that none of the Offices within DMH had complied with the planning statutes for many years. The Committees held joint public hearings in 2001-2002 to ascertain the impact of the lack of comprehensive planning.

Section 5.07 of the Mental Hygiene Law was enacted, as part of the 1977 reorganization of the DMH, to provide a blueprint for the establishment of statewide goals and objectives and comprehensive plans of services for the mentally disabled. The Legislature's purpose in enacting this statute was twofold: (1) to ensure that planning to meet the needs of mentally disabled persons, including the multiply disabled, would be an open, visible process, and (2) to enable the Legislature, in establishing funding priorities and program initiatives, to best facilitate the ability of the mentally disabled to live their lives in dignity and, whenever possible, in their home communities.

In addition, Article 41 of the Mental Hygiene Law was amended (Chapter 978 of the Laws of 1977) to facilitate an integrated planning process at the local level. The Declaration of Purpose, Section 41.01 states:

> "This article is designed to enable and encourage local governments to develop in the community preventive, rehabilitative, and treatment services offering continuity of care; to improve and to expand existing community programs for the mentally ill, the mentally retarded and the developmentally disabled, and those suffering from the diseases of alcoholism and substance abuse; to plan for the integration of community and state services and facilities for the mentally disabled; and to cooperate with other local governments and with the state in the provision of joint services and sharing of manpower resources.
>
> ". . .this article gives to a local governmental unit the opportunity to participate in the state-local development of such services. . ..It requires the direction and administration, by each local governmental unit, of a local comprehensive planning process for its geographic area in which all providers of services shall participate and cooperate in the provision of all necessary information. It also initiates a planning effort involving the state, local governments and other providers of service for the purpose of promoting continuity of care through the development of integrated systems of care and treatment for the mentally ill, mentally retarded and developmentally disabled, and for those suffering from the diseases of alcoholism and substance abuse."

The New York State Conference of Local Mental Hygiene Directors (CLMHD) was created by Section 41.10 of the Mental Hygiene Law. Membership is mandated to consist of the mental health director from each county and the City of New York. The Conference was given the powers to:

- Review and comment upon the rules or regulations proposed by any of the Offices within DMH for the operation of local and unified service plans and programs; and

- Propose rules or regulations governing the operation of the local and unified services programs.

Chapter 978 of the Laws of 1977 gave the CLMHD a prominent role in the 5.07 planning process. The CLMHD was given membership on the Mental Health Services Council and the Advisory Councils on Mental Retardation and Developmental Disabilities and Substance Abuse Services. The Legislature intended the CLMHD to be the entity representing local governmental units that would be able to provide input across systems to facilitate a viable, coordinated and integrated planning process.

The Mental Health Services Council and the Advisory Councils on Mental Retardation and Developmental Disabilities and Substance Abuse Services were given the responsibility to establish measurable statewide goals and objectives for each of the Offices within DMH, which would be reviewed on an annual basis by a process that was open, visible and accessible to the public. The Offices within DMH were then to formulate comprehensive five-year plans with annual updates. These plans were to be formulated from local comprehensive plans developed by each local government, with participation from individual consumers, consumer advocacy groups, service providers and department facilities. Section 5.07 specified, at a minimum, the information that was to be included in the annual plans. These plans were to be completed and due on October 1st of each year with copies submitted to the Legislature. This action was taken to establish a process whereby the plans could be considered by the Governor and the Legislature prior to the next Executive budget.

In addition, an interim report, detailing each Commissioner's actions in fulfilling the requirements of Section 5.07, including modifications being considered, was to be submitted to the Governor and Legislature no later than February 15th of each year. These reports were to also assist the Governor and Legislature in establishing programs and policies for the ensuing fiscal year.

Section 5.07 further requires each Office to prepare a three-year capital plan with annual updates that correspond to the statewide five-year plans. The Mental Health Services Council and the other two Advisory Councils are to review these plans and make recommendations. Copies of this plan, as well as the recommendations, are to be submitted to the Legislature on October 1st of each year.

The Legislature intended that this annual, bottom up planning process would reflect a partnership between state and local governmental units, and emphasize how gaps in services would be filled. Despite the mandates set forth by Section 5.07, for at least the past eight years, the Executive has ignored the planning requirements of the Mental Hygiene Law. As a result, local governments, service providers, advocates and consumers have not been able to plan for the provision of mental health services based upon locally identified needs. The consequence has been a disjointed, top down planning process that is inefficient, contrary to the intent of the legislation and facilitates wasteful use of public resources. This process has also hindered the Legislature's ability to establish policies and funding priorities consistent with the needs identified by local governments and other stakeholders.

The Committees determined that the planning process needs to be strengthened. Neither the Office of Alcoholism and Substance Abuse Services nor the Office of Mental Retardation and Developmental Disabilities has submitted a plan with annual updates, as required by Section 5.07 of the Mental Hygiene Law for several years. While the Office of Mental Health, under pressure from the Assembly Committee on Mental Health, submitted a planning document in 2003 for the years 2004-2008, the report did not comply with the requirements of the MHL. Further, none of the Offices within DMH has submitted a plan or annual update, as required by law by October 1, 2004. This non-compliance is consistent and ongoing. Reflecting DMH's ongoing failure to comply is testimony presented by Michael L. McClain, Associate Director for Community Affairs for Stony Brook Hospital, on January 24, 2002, before the joint Assembly Committees. The following is an excerpt of his testimony:

> "Section 5.07 of the Mental Hygiene Law is based on three principles. The first is that state and local governments must work together to address the needs of people who are mentally ill or mentally retarded. The second is that the needs of the mentally disabled will best be served if the three offices that comprise the Department of Mental Hygiene coordinated their activities, especially with regard to serving the needs of the multiply disabled. The third is that planning cannot be left entirely to public officials - it must include the voices of all the people who are affected by mental hygiene policy - recipients of services, their families and advocates, providers, and interested citizens.
>
> "The plan described in Section 5.07 is balanced and rational, both in terms of planning process and the plan's content. If such a process was implemented and a plan actually developed, we might be able to avoid some of the problems that have historically been associated with county care and state care. If there were an open public process for setting statewide goals and priorities, if the process were informed by data and grounded in locally identified needs, and if the plan were actually transformed into funding and programming to serve the needs of the people who are mentally disabled, the State of New York might once again find itself in the position it was a hundred years ago - a world leader in the provision of progressive, effective, and humane care to some of its most vulnerable citizens.
>
> "Unfortunately, the gap between the ideals stated in section 5.07 and the realities of the state planning process is obvious to any interested observer. . .we look to you to re-energize the planning process - to provide not only the legal basis for planning, but the commitment and resources necessary to ensure that it will actually occur as it was envisioned twenty-five years ago."

Assembly bill A. 5946-A, sponsored by Assembly Mental Health, Mental Retardation and Developmental Disabilities Chairman Peter M. Rivera is a first step to addressing weaknesses in system planning and coordination. Passed by the Assembly in 2004, A. 5946-A contains the following provisions:

- Establishes a Chairperson of the IOCC who is independent of any of the Offices within DMH;
- Gives the IOCC the responsibility for planning and delivery of services to the multiply disabled;
- Establishes the Council for Mental Hygiene Planning, with members to be appointed by the Governor and the Legislature, which will establish statewide goals and objectives for meeting the needs of the multiply disabled;
- Requires the Advisory Councils of each of the Offices within DMH and the IOCC to hold public hearings regarding the identification of goals and objectives, and to transmit them to the Legislature;
- Orders the Chairperson of the IOCC and each of the Commissioners of the Offices within DMH to annually certify that each five-year plan has been formulated in conformance with the statewide goals and objectives established by the appropriate Advisory Councils;
- Requires public hearings on the five-year plans; and,
- Establishes demonstration programs to train, transfer and assign employees of state operated hospitals to local governmental units and voluntary agencies, taking into consideration those areas of the State in greatest need.

The ability of local governmental units to plan for service delivery, particularly for those mentally disabled persons who are not Medicaid eligible, has been hindered by the lack of planning by the Offices within the DMH. Significant changes in authority and service delivery have occurred due to the increased utilization of Medicaid as the preferred funding mechanism. Planning by the Offices within the DMH and by other state

human service agencies that provide funding or services for the mentally disabled need to take into account the impacts their strategies will have on such populations, local governmental units and service providers.

Increased utilization of Medicaid funding to reduce state costs and the concomitant addition of new county Medicaid costs has stressed already thin local resources by raising local property tax burdens to pay for the local share of Medicaid. Funding streams, such as reinvestment funding, that previously offered a degree of flexibility to the localities have been eliminated in order to convert these to Medicaid funding. In many cases, Medicaid's more restrictive and stringent requirements reduce flexibility that is needed to ensure the best possible fit between the individual's needs and the services provided.

The OMRDD, in many cases, has been particularly successful in utilizing the Medicaid waiver process to eliminate the state and local share of Medicaid costs for much of its constituency. The OMH and OASAS have been less successful. However, as OMRDD has maximized access to federal resources, it has minimized the involvement of local governmental units in planning for the delivery of services to its targeted populations resulting in gaps in services, particularly for the multiply disabled.

The OMH has pursued a policy of Medicaid growth moratorium for the past several years. This policy does not allow for expansion of Medicaid related services if it will result in additional state costs. This has hindered the ability of local governments and service providers to plan for and respond to the needs of persons with mental illnesses, particularly those with multiple or co-occurring disabilities. Neither the OMRDD nor the OASAS pursues this policy.

An example of maximizing Medicaid funding in order to minimize the fiscal impact on the State is the OMH implementation of Personalized Recovery Oriented Services (PROS). According to the OMH **Statewide Plan for Mental Health Services 2004-2008**, PROS is a comprehensive outpatient service that integrates treatment, rehabilitation and support, and also incorporates accountability, best practices, and coordination of care. According to the OMH, PROS is another step toward simplifying the community-based mental health system, making it more consumer-oriented and meeting the spectrum of outpatient mental health needs.

As the OMH has moved forward to implement PROS, the Executive has removed funding from previously 100% state funded programs that provided local governmental units with flexibility to meet the needs of their mentally disabled constituencies. For example, cost effective and successful initiatives, such as self-help and peer support services, have seen their funding reduced in the 2004-2005 state fiscal year. When the Legislature attempted to restore funding for these services, the Governor vetoed the restoration. The result has been that self-help and peer support services, which the OMH has included in its priority set of evidenced based practices in recognition of how they compliment treatment and as a life long support which promotes the process of recovery, are in jeopardy.

Recommendations regarding Planning:

The Task Force Committee on Intergovernmental and Strategic Planning makes the following recommendations designed to strengthen the planning process, complimentary to A-5946:

1. Consider merging the planning processes for the Offices within DMH into the IOCC. Each Office would retain its planning functions while coordinating them with the IOCC.

2. Require the Chairman of the IOCC to submit the annual plan for all the Offices within DMH.

3. Provide adequate funding for planning at the local levels to allow Local Government Units, as defined in the MHL, to implement and complete their planning processes and local needs assessments on a regular and ongoing basis. The planning constructs must include co-occurring, dually diagnosed, and co-morbidity constituencies. Identification of ethnic or cultural issues that impact on the ability of certain segments of the population to access services should be mandated, as well.

4. Streamline and simplify the planning process, including establishing uniform timeframes, documentation and processes across all Offices of DMH.

5. Require a June 30th submission date for the plan required by the MHL so that mental hygiene constituencies and the general public can have sufficient time to review and comment on the efficacy of the plan prior to the submission of agency budget requests to the state Division of the Budget. It will also help inform and guide the Executive budget and the Legislature as it deliberates the submission of the annual Executive Budget Requests related to the mentally disabled.

6. Require the Commission on Quality of Care for the Mentally Disabled (CQC) to review the planning process and the plans required by the MHL and report annually to the Governor, the President of the Senate and the Speaker of the Assembly on the compliance of the Offices within DMH with the MHL. The CQC should be provided with sufficient and appropriate funding to accomplish this requirement.

7. Ensure that local and regional planning processes are transparent, consumer and family focused, and reflective of local or regional fiscal, program and human resources. Plans should require a gap analysis that details the current state of the service system, the goal for the service system, and how the system will progress toward the goal.

8. Ensure that local and regional planning includes a viable role for state employees of the Offices within DMH in the delivery of services in a community-based service continuum.

9. Examine the current single source management of Medicaid funding and the increasing use of Medicaid funding in the delivery of mental hygiene services. As funding has shifted to a centralized Medicaid authority, there have been a concomitant increasing number of problems and barriers associated with planning, accountability and service delivery at the state and local levels. The required 5.07 plans should document any strategies to shift or increase Medicaid funding for services and the implications of these shifts.

Interagency Coordination

The fragmentation of service delivery for the mentally disabled has led to an inefficient system that does not use public resources wisely nor does it focus on the needs of the mentally disabled and their families in a comprehensive and coordinated manner. The needs of the multiply disabled have received little attention as the Offices within the DMH have focused on their primary populations from the perspective of exclusive diagnostic categories. The lack of coordination across systems between human service entities that provide services to the mentally disabled has made it impossible to focus on the needs of the whole person. Rather, each system (e.g. Education, Health, Aging, etc.) focuses on particular needs of individuals consistent with the categorical funding available to them.

Contrary to the intent of the legislation that reorganized DMH in 1977, the division of responsibilities between the three Offices within DMH has led to a complex regulatory environment that limits the ability of providers to respond to the needs of the mentally disabled, particularly those individuals who suffer from multiple disabilities.

Individuals with multiple disabilities need assurance that their right to treatment is the same as that of persons with a single disability. For example, persons with schizophrenia or manic-depressive illness often seek street drugs, such as alcohol and marijuana, as a means of relieving or mitigating the ill effects of their mental health state. Regulatory and licensing requirements often hinder the ability of service providers to meet the needs of such individuals. Health care professionals are often uncertain whether to classify the primary clinical diagnosis as mental illness or substance abuse, which can result in the inability of individuals with such co-occurring disorders to receive services appropriate to their needs from either the mental health or substance abuse systems.

In March, 2000, the New York State Conference of Local Mental Hygiene Directors issued a report entitled, **Integrating Services for Co-Occurring Disorders**, which highlighted persistent and frustrating barriers to providing services to the population with co-occurring mental illness and chemical abuse disorders. The report recommended: a single point of assessment with agencies co-located in a single building; a central assessment unit with cross-trained staff, and a single assessment instrument that meets all regulatory requirements. The report concluded that system-level integration of provider agencies is important but it is not sufficient. Federal, state and local leadership are required to establish and implement a framework to initiate and promote innovations.

In 2002, the Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities held joint public hearings with the Committee on Alcoholism and Drug Abuse to review issues of concern related to those individuals with co-occurring disorders. It was apparent from testimony received that there are a number of regulatory and licensing issues between OMH and OASAS that hinder the ability of service providers to address the needs of such individuals. The Committees received a number of recommendations to improve the service delivery system, including merging OASAS and OMH.

In 2004, the Executive recognized the concern regarding fragmentation of the existing human service delivery system and created the Most Integrated Setting Coordinating Council. The Coordinating Council is exploring and will recommend ways to ensure that New Yorkers with disabilities receive services in the most integrated settings appropriate to their individualized needs. The Council consists of representatives from the Offices of Mental Health, Mental Retardation and Developmental Disabilities, and Alcoholism and Substance Abuse Services within DMH; the State Office of the Aging; the Office of Children and Families; the Departments of Education, Health, and Transportation; the Division of Housing and Community Renewal; the Commission on Quality of Care for the Mentally Disabled; and the Office of the Advocate for Persons with Disabilities.

Several state and local governments have taken steps to address the issue of fragmentation and lack of coordination between human service entities. Florida reorganized its human service entities at the state level by merging its alcohol and substance abuse programs within its mental health system and merging its mental health system within its Department of Children and Family Services. The city of Philadelphia merged its alcohol and mental health license resulting in reduced regulatory costs. Philadelphia also established a central intake system that refers individuals to the appropriate services resulting in reduced costs for care delivery and modified its regulatory system to take advantage of Medicaid waiver opportunities to more flexibly respond to the individualized needs of the mentally disabled.

In New York State, Monroe County established an Interagency Council, representing a broad base of mentally disabled consumers, providers of services, and county agencies, including BOCES, to identify and address barriers to an integrated system of service delivery for the mentally disabled. In the Finger Lakes, ten rural counties have organized a regional construct, in conjunction with the Elmira Psychiatric Center, to better utilize available resources to meet the needs of the mentally disabled. In 2003, New York City merged its alcohol and substance abuse programs within its mental health system and placed the mental health system within its Department of Health and Mental Hygiene.

On July 30, 2002, legislation was enacted (Section 448 of the Executive Law) to establish a Children's Coordinated Services Initiative (CCSI). The following is an excerpt from this legislation:

> "§ 448. Coordinated children's services for children with emotional and/or behavioral disorders. 1. Purpose. The purpose of this section shall be to establish a coordinated system of care for children with emotional and behavioral disorders, and their families, who require assistance from multiple agency systems to appropriately maintain such children with their families, in their communities and in their local school systems. Such system of care shall assure effective collaboration among state and local health, mental hygiene, education, juvenile justice, probation of care and other human services agencies directed at improving outcomes for children with emotional and/or behavioral disorders and their families leading to full participation in their communities and schools. This shall include children with co-occurring

disorders. The absence of coordinated care often results in inappropriate and costly institutional placements and limited community-based services that support maintaining the child in the community. Establishing the coordinated children's services initiative statewide is intended to improve the manner in which services of multiple systems are delivered and to eliminate barriers to a coordinated system of care."

This legislation established a three-tier system that allowed for coordination between human service agencies at the State and local levels. This legislation also allowed for the establishment of pooled funding at the local level so that the needs of mentally disabled children could be addressed in a flexible manner. It is clear that this type of initiative should also be extended to mentally disabled adults.

Recommendations regarding Coordination:

The Task Force Committee on Intergovernmental and Strategic Planning makes the following recommendations, building on legislation (A. 5946), designed to strengthen interagency coordination:

1. Create an Independent Chairperson of the Inter-Office Coordinating Council (IOCC) with specific responsibilities related to the multiply disabled and the submission of the 5.07 plan and annual updates on behalf of the Offices within DMH.

2. Support integrated treatment, encourage demonstration projects, facilitate collocation of mental health, addictions and mental retardation services, and streamline regulations, funding and operational structures to enable seamless, integrated services for individuals with co-occurring disorders.

3. Add to the IOCC, the CQC, the Conference of Local Mental Hygiene Directors, and the Chairpersons of the Mental Health Services and the Chairpersons of the Advisory Councils who are responsible, by statute, for establishing statewide goals and objectives for the mentally disabled.

4. Create a committee of consumers, providers and families under the IOCC to make recommendations to improve the coordination of services for the multiply disabled between the Offices within DMH.

5. Create an Interagency Coordinating Committee under the IOCC, including, but not limited to, the state agencies participating in the Most Integrated Setting Coordinating Council to:

    a. Address cross-system issues.

    b. Simplify regulations to decrease costs and enhance provider flexibility.

    c. Establish a single licensing process for providers of services for the mentally disabled. A single application source with regulatory authority across the three Mental Hygiene Offices would facilitate improvement in cross-system approaches to service provision.

    d. Create an Adult Coordinated Services Initiative (ACSI). This initiative would draw upon and adapt from the principles of a successful paradigm for children in New York, the Coordinated Children's Services Initiative, which has been widely and successfully adopted.

    e. Recommend ways to pool resources at the local level to enhance flexibility and to establish a consumer focused system of service delivery.

    f. Enable consideration of the needs of individuals with co-occurring disorders.

6. Consider establishing separate regulatory and operational entities at the state and local levels. State and local entities performing regulatory/management functions would be divested of any direct service provision. This would eliminate the conflict of interest inherent in performing both roles.

7. Establish mechanisms for creation of regional constructs, including cross-system constructs, particularly in rural areas of the State, responsive to local needs and resources. These regional constructs could be utilized for the provision of services through a provider or providers across a multi-county region or be utilized to combine management and regulatory functions as a single entity for a multi-county regional area. This would facilitate maximizing use of all available resources and would create efficient management and service capacity that would otherwise be unavailable.

8. Co-locate all DMH regional and field offices to address multiple cross-system needs.

B. CONTINUUM OF SERVICES

The continuum of services in a comprehensive system of care addresses the behavioral health needs of the entire community, providing public education, a focus on health promotion, prevention and early intervention, and a balanced array of treatment and recovery support services designed to meet the behavioral health, medical, social, housing, supportive and rehabilitative needs of individuals and families. This comprehensive system should be person-centered, providing choice and meeting defined quality and patient satisfaction goals to facilitate recovery and maximize independence. A continuum of services must recognize that recovery from mental illness is a process that is unique to each individual within broad parameters. Some individuals reach their highest level of functioning and still require a level of ongoing intensive support. Incentives for coordination and integration with other health and human services are essential to meet the manifold needs of mentally disabled individuals in the most efficient and cost effective manner. While research to establish evidence-based best practices should be encouraged, there exists a wide range of established and promising practices that providers and consumers have found to be effective.

The continuum of services should function in response to individual factors of culture, age, gender, economic and social criteria that condition the need for service. For example, as people age, their needs change. Children's needs differ from those of young adults. The needs of seniors differ from those of mature adults. The organization and financing of services should encourage cost-effectiveness and responsiveness to consumer-determined rehabilitation and recovery goals. This requires a critical look at the use of rigid and categorical funding guidelines in terms of the types of services that are funded. The system must be adaptive and flexible in order to serve all members of the community including:

- Children and youth and their families
- Adults and Seniors
- Special Needs Populations (e.g. mental illness/chemical dependency, mental illness/developmental disability, and forensic)
- Individuals experiencing psychological symptoms secondary to experiences such as disasters, crimes, physical injuries, etc.

Core Attributes of an Effective Continuum of Services

There are four core attributes to an effective continuum of services: Accountability, Coordination, Integration, and Access to Care.

Accountability

Accountability at all levels of the system is required to advance the delivery of quality services that are evidence-based and able to demonstrate clinical outcomes that promote individual rehabilitation and recovery.

Government, with input from client, provider, academic and other stakeholders, is responsible for the development of clear goals and objectives designed to achieve specific and measurable outcomes through a

comprehensive population-based planning process; and the development of policies and incentives to promote service integration, coordination and collaboration between agencies, services and across systems. There needs to be accountability such that it is clear that "The Buck Stops Here" when it comes to service delivery and transitions across levels of care.

In order to achieve an accountable system, state policies must support interagency collaboration and the use of appropriate guidelines and incentives to promote adherence to state-of-the-art practices. Over the years, fragmentation of services across systems has led to a fragmentation of responsibility. For example, patients often linger in acute care facilities and state psychiatric centers due to jurisdictional issues about which state agency has responsibility for the patient and due to a lack of step-down facilities for those ready to leave hospital settings.

Service system design must be based on needs assessments and best practice research regarding treatment efficacy and client outcomes, with input from all stakeholders. Where available and appropriate, guidelines should be incorporated into treatment practices and all providers must be held accountable to this process.

Barriers to Accountability:

- There are multiple levels of bureaucracy within the mental hygiene system and across human service systems that hinder development of a continuum of services.
- Since there is no single entity accountable for services coordination and integration, there is inconsistent enforceability.
- Methodologies that measure client outcomes need to be developed and implemented.
- Providers are risk averse because of the realistic fear of costly litigation and the potential for unreasonable liability when they serve high risk and volatile individuals.
- There is a conflict of interest between state and local governments as both providers and regulators of services.
- There exists a lack of adequate resources in certain areas (e.g. housing, child psychiatry, geriatric psychiatry, etc.).

Recommendation regarding Accountability:

Establish demonstration projects to test various methodologies of service system accountability, including "one stop shopping," use of technology to create "virtual" services integration, and other approaches to assure system-level accountability. These demonstration projects would include regulations applicable across the Mental Hygiene Offices.

Coordination

Coordination is required on both the systems and service delivery levels. The array of medical, psychiatric, social, and rehabilitative services should be organized around the needs and desires of the individuals with appropriate incentives to providers to participate effectively in the care continuum.

In a client-centered system of care, coordination is critical. One must recognize that no single state or county agency works in isolation in responding to the needs of the mentally disabled. Effective care coordination allows for easy movement between levels of care and across service areas.

Agencies and individual providers work collaboratively to ensure continuity and coordination of services. Care coordination is the glue in the system that supports continuity of care and allows for the development of effective accountability for clinical outcomes.

As children transition to young adulthood, coordination of service delivery is essential. For example, foster care does not prepare children for independent living. When a child turns eighteen, he/she is out of foster care and must fend for themselves. Traumatic for any individual, it is more so for the mentally disabled. The results are often homelessness, substance abuse, contact with the criminal justice system, and in some cases, death by suicide.

Coordination between human service agencies can minimize these adverse outcomes and reduce expenditures of public resources for services that would otherwise be needed to address such negative outcomes. By working together and pooling resources, housing appropriate for transitioning youth can be developed. Educational and managed work programs that provide a system of supports by staff with clinical backgrounds to help persons with mental disabilities transition to employment and financial independence can be fostered. Recovery and independence would enable the mentally disabled to be contributors to society.

The cycle of recovery differs among individuals. Therefore, some people will require an array of services throughout their lives, including services for the most vulnerable within their housing environments. For those individuals who are seriously and persistently mentally disabled, coordination between human service systems can mean the difference between living in an institutional setting and living in the community. New models, such as therapeutic foster care as well as highly structured, intensive, transitional residential programs for individuals transitioning from acute or state hospitals to community placements or home, can be developed. Cost effective, outcome driven services and supports based on consumer needs can be utilized to keep such individuals in their communities.

Coordination among all human service sectors is critical in the event of a disaster. On September 11, 2001, New York City experienced a devastating terrorist attack that resulted in the deaths of thousands of New Yorkers. The OMH collaborated with the New York City and regional county mental health departments to address mental health needs stemming from this tragedy through the Project Liberty program funded with $155 million from the Federal Emergency Management Agency (FEMA). The possibility of additional terrorist attacks in the State of New York must be taken seriously. Formal mechanisms need to be established so that an array of human service responses can be immediately and effectively marshaled and coordinated to meet the mental health and other needs of the affected populations in the event of another terrorist attack or unforeseen disaster.

Barriers to Coordination:

- State fiscal policy does not provide incentives for collaboration among state agencies or between state and local agencies. Fragmentation of funding and mechanisms for interface between, for example, health and behavioral health or mental health and alcoholism and substance abuse, hinder flexible and efficient use of public resources.
- There exists a lack of incentives for collaboration between service systems and providers at the local level.
- Current regulatory and legal structures function along the lines of discrete episodes of care.
- Categorical reimbursement structures leave little flexibility to provide coordination.
- Clients access services from diverse public and private entities, including formal and informal care givers, etc. System reform needs to be mindful of the social context within which care is provided.

Recommendations regarding Coordination:

1. Establish consumer driven, coordinated points of access based upon geographic proximity to include an empowered care coordination system.

2. Reduce regulatory barriers.

3. Create a monetary reserve for mental health disaster care and services.

Integration

Service integration provides a holistic approach to the multiple needs of consumers and families. Services may be provided at a single site or through seamless linkages between levels of care and across the range of services. The concept of one-stop, seamless service delivery, linking primary care and behavioral health to provide early identification and intervention, is an example of service integration and is considered a best practice, according to **Mental Health: A Report of the Surgeon General (1999**).

There is a need to develop integrated health, behavioral health and social service networks to address individual needs in a comprehensive manner in order to support rehabilitation and recovery. School-based health programs need to integrate mental health assessment and referral components into their programs. On site services should be available, if needed.

Many people receive mental health services from their primary physicians. There is a stigma associated with mental disabilities in many of the cultural subsets that make up New York's population. Some individuals may be willing to see their primary physician or visit a health clinic but are not willing to go to a mental health clinic or practitioner. Linking primary care and behavioral health can help mitigate the stigma sometimes attached to a mental disability.

Funding mechanisms, such as Medicaid, need to be made more flexible to allow for payment of more than one service in a day. This is particularly critical in rural areas of the State where transportation is a significant barrier to access. Bundling of services will reduce transportation costs, allow for the more efficient provision of multiple services at one site, and reduce the anxiety mentally disabled individuals may have in obtaining transportation or navigating the public transportation system.

Barriers to Integration:

- Categorical/Silo funding and reimbursement (including managed care programs) does not allow for a holistic approach to meet the multiple needs of consumers and families.
- Regulatory constraints (e.g. one visit reimbursed per day by Medicaid) limit the ability of service providers to address the needs of consumers in a timely and cost efficient manner.
- Lack of appropriately aligned incentives for integration, including competition among providers (primary care/specialty), hinders the development of an integrated system of services.

Recommendations regarding Integration:

1. Review reimbursement structures to provide incentives for integrated care at behavioral health, primary care and specialty provider level.

2. Require mental health screening as part of medical visits.

3. Increase efforts to integrate school-based health and mental health programs.

4. Cross train workforce in disability and illness domains and in disaster response.

Access to Care

The service system must meet the needs of individuals and their families providing access to appropriate, affordable and culturally competent care in a timely manner.

Access to care is critical in an effective service delivery system. Access begins at the point of birth with continuous screening and assessment for mental illness, mental retardation and developmental disabilities. Care should be available regardless of an ability to pay and located in areas accessible to the community. Transportation is a required component. There is an array of needs relating to the level of disability and scope of illness. Access to care should not be determined by a citizen's living situation or legal status, i.e., homelessness or incarceration. This will also require a culturally competent workforce with up-to-date technology.

There needs to be a data base that will enable consumers, primary care and other human service providers to identify points of access to a comprehensive system of services. Consumers need to be able to choose the entry point and change it if they are not satisfied.

The OMH has begun implementing a Single Point of Access (SPOA) process, creating centralized intake and referral systems to prioritize access to services based on need level. According to the OMH Statewide Comprehensive Plan for Mental Health Services, 2004-2008, counties have considerable flexibility in structuring their SPOA systems, as long as the general purposes of SPOA are addressed. Unfortunately, in some cases SPOA has created a funnel, which has hindered the ability of consumers to access the service system and limited the flexibility of local governmental units to respond to the needs of the mentally disabled in a timely manner. Multiple entry points based on geography and population size, each of which would be responsible for the consumer throughout the process to recovery, would reduce the log jam and facilitate a timely response to consumer needs. A needs assessment methodology can be utilized to determine the number and locations of entry points.

Barriers to Access:

- The lack of insurance parity, which limits reimbursement for treatment of a mental disability as compared with other medical conditions.
- Budget and regulatory restrictions discourage development and implementation of comprehensive, cost efficient points of access and treatment services.
- Eligibility restrictions based on regulations or categorical funding mechanisms limits system access.
- The lack of capacity of services due to the absence of insurance parity, budgetary and regulatory restrictions.
- Location and transportation issues hinder access to services.
- Primary care physicians fear opening "Pandora's Box" by diagnosing and attempting to treat a mental illness.
- Many people fear identification of, and the stigma related to, mental illness/chemical dependency/MRDD.
- The belief in certain cultures that these illnesses and disabilities reflect a "moral failing" and/or that they are willful.
- Language and cultural barriers (the shortage of multilingual professionals and a workforce trained in cultural competencies) hinder the ability of the service system to expand access.

Recommendations regarding Access:

1. Enhance financial resources, including establishing insurance parity.
2. Implement public education campaigns and legislative and executive action to address discrimination and stigma, and insurance parity.

3. Recognize the diverse needs of persons with serious and persistent mental illness and dually diagnosed individuals experiencing other conditions (e.g., traumatic responses).

4. Establish workforce enhancement initiatives to include loan forgiveness and recruitment programs.

5. Develop a physicians' extender workforce to include, but not be limited to, psychiatric physician assistants and psychiatric nurse practitioners.

6. Fund consumer/peer counselor training programs and support the expansion of integrating peers in the workforce by including them in program services such as ACT Teams, Emergency Rooms and Inpatient Units.

7. Explore incentives to universities for cultivating culturally competent students.

8. Provide incentives to expand rehabilitative and recovery focused services that connect with ticket to work and welfare reform employment programs.

C. UNDERSERVED POPULATIONS

An accessible, accountable, coordinated and integrated continuum of services will address the needs of the underserved populations in New York. Underserved populations are those in which a significant proportion of its members, who require services for mental disabilities, do not receive any form of treatment or experience significant obstacles to receiving adequate comprehensive services. The OMRDD has responsibility for developmentally disabled people throughout their lives, as defined by Section 1.03 of the MHL. The MHL does not similarly address the needs of persons with mental illnesses or other mental disabilities. According to the U.S. Center for Disease Control and Prevention, it is estimated that less than half of the adults, one third of children, and a quarter of the geriatric population with mental illnesses receive the services they require.

Although recognized as substantial, the various impacts of mental illness on the community, particularly among underserved populations, have not been measured to a great extent in New York. Such impacts include: economic costs associated with use of high cost emergency/crisis health services; financial costs and lost productivity to family members and affected individuals; and, diminished quality of life of affected individuals and their significant others.

There exist a number of groups of people who, because of difficult circumstances or conditions, are at special risk of being affected by the burden of mental problems. These groups include: persons living in poverty; children and adolescents experiencing disruptive nurturing and living conditions; persons traumatized by violence in various forms; recent immigrants; and, members of various ethnic groups. Many persons subject to these disadvantaged situations share sociological markers such as unemployment, social disintegration, unmet housing needs, stigmatization and comorbidity with medical, addiction and developmental conditions.

> **Ethnic-Cultural Groups:** Stress and other predictors of mental health and substance abuse problems are consistently high within minorities, particularly immigrant populations. Immigrants and refugees are frequently the survivors of trauma in their home countries, and experience high levels of economic and social marginalization intensified by communication barriers. The lack of availability of adequate mental health services in languages other than English, coupled with under-utilization of available services by minorities resulting from fears, costs, and stigma, point to an area of fundamental need in New York. Even though the NYS OMH and the NYC DHMH have attempted to address the needs of ethnic-cultural groups as a priority, evolving immigration patterns and concentration of poverty and other barriers in some ethnic groups, result in severe disparities among *African-, Arab-, Asian-, Caribbean-, East-European-, and Hispanic-Americans* in the State of New York.

Groups With Unmet Housing Needs: According to the 2004 NYC Census by the NYC Department of Homeless Services, currently there are more than 38,000 *homeless* children and adults just in the City of New York. Since 1998, the shelter population has increased by 82%. It is estimated that the majority of homeless adults are mentally ill and/or affected by addictions. In New York City alone there are an estimated 10,500 homeless single adults with mental illness on the streets and in shelters and another 600 homeless families with a mentally ill adult family member. In addition, as a result of homelessness related stress and discontinuity of care, homeless individuals with mental illnesses are the main recipients of the highest level of health care provided by inpatient units and emergency rooms, and consume the greatest share of other emergency resources such as homeless shelters and outreach teams.

Consequently, this population is over-represented among individuals requiring inpatient, residential and community psychiatric and substance abuse treatment. Moreover, it is estimated than 20% of the *individuals with criminal justice system contact* are in need of services for mental disabilities. This group often joins in the revolving door that transports them through an endless cycle of hospitalization, incarceration, and stints on the streets and in shelters. Due to incarceration and discontinuation of entitlements, many require high cost health services. Other groups with inadequate access to appropriate community housing resources include *those living with aging or disabled family members and adult home residents* with a mental illness who could live in a more independent residential setting, but have no access to more independent types of housing.

High-Risk Demographic Groups: Center for Disease Control and Prevention data demonstrate the high prevalence of untreated depression, addictions, trauma and other mental disorders among *children, adolescents, young adults and the elderly*. The Surgeon General has estimated that 20% of the geriatric population have a mental disorder (not including substance abuse) yet, a large proportion of the elderly with mental illnesses do not receive psychiatric services. A survey of students in the New York City school system revealed that 14% of the adolescents surveyed have thought about committing suicide, yet school-based mental health and family support services are limited. Even though most of the epidemiological data available is restricted to inner city areas, it is estimated that rural areas experience a greater shortage of mental health services for the elderly and the young, resulting in high percentages of underserved populations.

Specific Disabilities and Comorbidities Groups: Many individuals are not receiving mental health services in spite of meeting diagnostic criteria for several mental illnesses, *including depression, anxiety disorders (including post traumatic stress disorder and other consequences of trauma)*, pathological gambling and addictions. For example, while the state of New York has embarked on the most significant expansion of gambling opportunities in the history of the state to enhance public revenues, funding for prevention, education and treatment programs is minimal. The social and economic impacts of pathological and problem gambling on families and communities are significant, yet the state of New York has made few provisions to address impacts that its own policies foster. Populations affected by a dual diagnosis, such as mental illness and addictions, mental illness and developmental disabilities, or mental illness and severe medical conditions, are underserved as a result of the lack of integration and coordination between the departments of Health, OMH, OASAS and OMRDD. In addition, the relative lack of integration of a mental health component at the primary care level accounts for a high morbidity and poor mental health and physical outcomes for *mentally ill individuals affected by medical conditions*.

Unengaged, Uninsured and Ill Insured Groups: The lack of insurance parity related to mental illness has resulted in a type of discrimination against people with mental health needs and addictions who don't receive the same insurance coverage as those with physical illnesses, and are often subjected to higher cost sharing and lower utilization limits. The high cost of medical (psychiatric) services and medications, stigma, and mistrust discourages a significant portion of the population from utilizing services that can identify and treat mental disabilities effectively and efficiently. Consequently, utilization of such services occurs only when their needs reach a crisis threshold and lead to homelessness, incarceration, severe mental illness or deterioration of severe medical conditions, resulting in their becoming a recipient of high-cost services.

Barriers to Mental Health Care:

A wide range of barriers to seeking mental health care has been identified in the mental health literature (U.S. Department of Health and Human Services, 2001). These identified barriers can be organized into several dimensions, including barriers in the service system, community-level barriers, provider barriers, and person-centered barriers. Additionally, there are cultural and linguistic barriers, as well as immigration related barriers. However, these barriers are not isolated, but rather tend to be compounded for vulnerable populations. For instance, the family that does not have health insurance may not have transportation, may not speak adequate English and may not know that preventive care is necessary. These barriers result in the provision of poor quality mental health services in the underserved populations, which impact family stability and hinder community and economic development.

- **System barriers** include lack of health insurance, language barriers, and a lack of information about services (especially for populations with poor English proficiency). Other important system barriers include the lack of coordination and integration of categorical programs coupled with poor coordination and integration for primary care, specialty care and enhanced services, resulting in fragmented care. The structural separation of mental health, health, substance abuse and other systems makes integration difficult. Regulations regarding what services can be provided under what licenses also makes it difficult to provide integrated services. In this regard, there is ample evidence of lack of adequate integration of the mental health system with the education, housing, primary care, adult and juvenile justice, and children and adult welfare systems. Particularly critical is the serious shortage of mental health professionals who are culturally and linguistically competent within monolingual communities, as well as the lack of ethno-cultural appropriate training for mental health professionals. The combination of these factors results in a relative lack of adequate ethno-culturally competent services.

- **Community centered barriers** include the stigma of mental illness, as well as a lack of familiarity with the mental health system and/or fear of the system. This is particularly true for poorly acculturated and minority groups. Individual and community beliefs and attitudes about the value of care or the importance of prevention may also present barriers.

- **Provider barriers** include limited access of those without health insurance, and managed care plans that generally limit services in the same way commercial plans do. For example, there may be an inability to offer needed services in a particular clinic or for a particular consumer due to limitations to Medicaid services. Providers who are poorly trained in providing ethno-culturally competent services often fail to properly engage their patients in treatment, leading to higher rates of recidivism. Reluctance by providers to do outreach within underserved communities, coupled with a lack of appropriate outreach materials leads to a lower concentration of this population in treatment. Providers cite poor reimbursement and daunting paperwork as barriers. Additionally, some providers:

    - lack skill of engagement;
    - lack interest in outreach;
    - over-rely on medical models and the model of serving people in offices;
    - are reluctant to serve "difficult" populations, such as those who do not respond to psychotherapy, have a history of crime or violence, co-occurring disorders, or live in neighborhoods that are not appealing to some providers.

- **Person-centered barriers** include lack of recognition of mental health problems, stigma of mental illness, and a self-reliant attitude. Many people do not know that treatment works or where to go for treatment. They tend to go for help to sources other than mental health professionals, including clergy, primary care physicians, social services, and other sources of help indigenous to their cultures.

- **Cultural and Linguistic barriers** impact the ability of people to identify and access services for mental illness. According to the Year 2000 Census, minorities represent the majority (62 %) of the NYC population (Hispanics - 27%; African Americans - 25%; and, Asians - 10%). Forty-seven percent (47%) of New York City households speak a language other than English at home, and more than one-quarter of the City's residents are limited-English-proficient, meaning that they would not be able to undergo a psychiatric evaluation, crisis intervention, or counseling using English. According to the 2000 NYC census, 921,324 individuals spoke only Spanish, 221,715 only Chinese, 125,665 only Russian and 52,782 spoke only Korean. The enormous shortage of trained bilingual and bicultural counselors, therapists, psychiatrists and social workers, make it impossible for many limited-English-proficient New Yorkers to obtain referrals and timely, appropriate mental health services. This situation has been made worse by the absence of trained medical and mental health interpreters in New York's clinics and hospitals. While mental health services are unfamiliar or culturally suspect to many newcomers, the fact remains that immigrants who seek care or are referred for such services typically face delays of weeks and months to be seen by a provider who can speak their language. Communities outside of New York City are experiencing similar difficulties as cultural and ethnic minorities migrate to their communities from New York City and elsewhere. It is clear that the proportion of mental health professionals who render services in a language other than English falls far short of current needs, and will constitute a critical service gap for many years to come.

- **Immigration-related barriers** impact the ability of immigrants to identify and access services for mental illness. Among New York City's 3 million immigrant residents, roughly 500,000 are undocumented immigrants who are categorically barred from public insurance in Medicaid and Family Health Plus. While immigrants are as likely to be employed as native-born New Yorkers, immigrant workers are less than half as likely to receive health insurance coverage through their employers. Immigrants are also faced with a set of distinct concerns that severely limit their access to needed care: few immigrants understand their rights to mental health care, including counseling and treatment services; many are low-income and lack insurance; and, most are unaware of the options for affordable care such as sliding-scale fees. Significantly, many immigrants - legal and undocumented alike - are afraid of perceived immigration consequences of using various services and benefits. The immigration status of parents constitutes a well-documented barrier to care for children, even when these children are themselves U.S. citizens and are eligible for Child Health Plus. Many immigrants avoid enrolling in public programs or accessing the health care safety net due to a belief that doing so will interfere with their ability to sponsor and re-unite with close family members such as spouses, children, and parents who live abroad. Immigrant households are also increasingly concerned about the possibility of data sharing among health providers, public programs, and immigration authorities, which adds to the chilling-effect of policies directed specifically at immigrants such as public charge, sponsor liability, and restrictions on eligibility.

Recommendations regarding Underserved Populations:

1. Require OMH to conduct a study regarding the needs of underserved populations and how to best meet their needs, and to report their findings to the Governor and the Legislature. Particular focus should be placed on mentally ill individuals who are children and adolescents, elderly, ill-housed, those with poor English proficiency, and those with criminal justice system contact.

2. Ensure a planning process that is based on needs assessments, aimed at the development of a mental health system that is person centered, recovery oriented and reaches mentally ill individuals who receive sub-optimal services or no treatment at all.

3. Enact legislation, such as Timothy's Law, that would ensure that mental health and chemical dependency coverage is provided by insurers and health maintenance organizations and is provided on terms comparable to other health care and medical services.

4. Develop policy to build bridges across the various governmental agencies that oversee the care for multiply challenged individuals, including, but not limited to, DOH, OMH, OASAS, OMRDD,

housing agencies, corrections, and the criminal justice system.

5. Sustain and strengthen the capacity of mental health services at the primary care level, as well as in school-based clinics, to identify mental health needs, make appropriate referrals, and offer complimentary services in the community.

6. Devise a flexible funding system to help providers serve uninsured and undocumented patients.

7. Establish demonstration initiatives, grants and other incentives to promote and ensure the fiscal survival of programs delivering community mental health services to individuals with poor English proficiency and cultural minorities.

8. Develop a range of residential opportunities and support services to enable those with unmet housing needs to access housing consistent with their needs and plans of recovery. Such initiatives may include:

    - a new New York City/New York State housing agreement;

    - development of supportive and scattered-site housing units for mentally ill residents of adult homes seeking more independent housing alternatives, as well as a housing application assistance office to assist those residents and those who need to find new housing because of adult home closures; and,

    - a community mental health housing waiting list for mentally ill adults who have applied for, but who have not yet received, community mental health housing placements.

9. Develop, enhance and promote the role and functioning of peer counselors, nurse practitioners and physician assistants for underserved populations, particularly among minorities.

10. Allocate funds to support trained interpreters and community organizations that can enable immigrants to access existing mental health services and providers in their preferred languages and in accordance with their cultural beliefs and practices.

11. Increase the presence of minorities among senior officials, executives and leadership of relevant entities, including state and county offices of mental health, as well as in hospitals and community mental health organizations.

12. Develop a model of funding for new contracts and technical assistance in developing and sustaining community-based mental health programs.

13. Provide financial support and assistance to organizations to develop aggressive bilingual outreach and education campaigns aimed at: heightening awareness, acceptance, and understanding of mental illness; increasing knowledge about how and where to access services; and, reducing the stigma of utilizing mental health services and of people with a mental illness.

14. Create readily accessible financial assistance programs for graduate mental health education and/or other incentives, such as scholarships and loan forgiveness programs, for minority members to pursue a mental health profession at the graduate level.

15. Provide incentives so that service providers can attract and retain qualified bilingual and bicultural clinicians.

16. Develop cost efficient and easy to follow mechanisms under which foreign-trained mental health professionals can be assessed and credentialed in New York State if qualified.

17. Reduce current restrictive licensing requirements for health practitioners in New York in order to reduce the loss of bilingual qualified mental health professionals to other states with less restrictive requirements.

18. Require institutions of higher education to create and/or enhance their training for human service professionals to include topics such as cultural competence, cultural diversity, racial relations, or working with specific racial and ethnic minority groups.

19. Accelerate cultural competence research (policy, organizational and clinical) to develop a scientifically grounded body of knowledge on best practices for minorities and other specific underserved populations.

D. RESOURCES

The availability and construct of resources, public and private, impact on the service delivery systems for the mentally disabled. Such resources include funding, capital infrastructures, and human resources. Private funding includes private pay and insurance. Public funding comes from the federal, state and local governments.

There is a need to ensure that services for the mentally disabled are adequately funded. At the same time, oversight mechanisms need to be in place to reduce fraud and the wasteful use of public resources.

In 2004, the Assembly passed legislation known as Timothy's law to require mental health insurance parity. This private source of funding can help thousands of New Yorkers meet their mental health needs without the need for public funding. Studies have shown that insurance premium increases are negligible in states that have implemented mental health parity. Unfortunately, negotiations with the Senate did not result in legislation that could be sent to the Governor for his signature.

Medicaid

The State has placed a high priority on maximizing federal Medicaid funding. During the 1970s and 1980s, Medicaid was used to expand community-based programs for the mentally disabled. Instead of requiring the spending of 100% state dollars for certain inpatient and community-based programs, the federal government paid 50% of the costs. Under the current administration, Medicaid has been used to replace state dollars for existing programs. The State has used Medicaid to reduce its commitment to the mentally disabled. Instead of recycling state funds saved by converting services to Medicaid into expansion of community-based programs to meet the needs of the mentally disabled, the State has removed resources from the system.

Medicaid funding requires, in most cases, a local government match. In the case of mental health services, the local match is 25%, saving the State additional funds. The policy consideration at the time the local match was mandated acknowledged that if local governments had a financial stake in the services delivered, they would exercise their fiduciary responsibilities to ensure that funds were expended appropriately and efficiently. Over the years, as Medicaid expenditures have increased, the burden on local governments, which rely primarily on property taxes for revenues, has stretched them to their financial limits.

The OMRDD has used the Medicaid waiver program to expand services while eliminating the local government match. As services for the mentally ill are converted to Medicaid, local governments need to be held harmless, their local share capped. This will help mitigate local opposition to program/service expansion for the mentally ill and enable local governments to use their available revenues for other identified priorities.

The OMH has begun implementation of a Medicaid waiver program called Personalized Recovery Oriented Services (PROS). This initiative is an effort to replicate the success that the OMRDD has had in maximizing federal revenues. At least initially, local governments will be held harmless. However, it is unclear whether local governments will continue to be relieved of their local match over time. As programs previously

funded by 100% state dollars are converted to Medicaid, state resources freed up should be recycled into the community mental health system to enhance flexibility of the system to meet the multiple needs of the mentally disabled. This would include funding non-traditional services that foster a recovery model.

The OMH originally intended to fully implement PROS statewide. However concerns regarding unintended and unanticipated consequences have been raised by consumers, advocates, providers, local governments and the Assembly Mental Health Committee. The OMH is now phasing PROS in slowly to assess its impacts before full implementation.

Cost Containment

In order to restructure the mental hygiene delivery system it is necessary to evaluate all programs and funding streams for efficacy and efficiency. This will help ensure that the impact of funding is maximized in addressing the needs of mentally disabled persons. Two diverse issues, the availability of psychotropic medications and the state Comprehensive Outpatient Program (COPS), are highlighted only to exemplify the variety of issues relevant to the discussion on ensuring the most appropriate and efficient delivery of mental hygiene services.

Advances in psychotropic medications provide the promise of recovery to thousands of persons with mental illnesses. The fiscal impacts of the benefits of these medications need to be analyzed in relation to the avoided costs that would otherwise be incurred if such medications were not available. The Centers for Medicare and Medicaid Services (CMS), on August 2, 2004, issued a report entitled, *Psychotropic Medications: Addressing Costs without Restricting Access*. For FY 2002, states reported the costs of prescription drugs as the most significant factor contributing to higher total Medicaid spending. States reported that increasing pharmacy costs resulted from increased utilization, new and more expensive medications, price inflation for existing products, and pharmacy driven capitation rate increases for managed care organizations. States have used a variety of techniques, including mandating the use of generics, limiting the number of prescriptions that may be filled in a single month, imposing beneficiary co-payments, requiring prior authorization, and using fail-first policies. The fail-first policy is a requirement that as a prerequisite for authorization of a specific, often non-formulary medication, the patient must fail on at least one other medication (often involving multiple tries).

In 2001, the National Association of State Medicaid Directors (NASMD) and the National Association of State Mental Health Directors (NASMHPD) met and produced a joint report on psychotropic medications. The report concluded that restrictive measures alone were unsuccessful, and pointed to the need to manage costs in the context of appropriate usage. It also recommended that agencies develop programs to improve provider compliance with medication use guidelines, and identify educational mechanisms for providers and consumers regarding appropriate medication use.

Since 1991, New York State has been providing supplemental Medicaid payments to certain outpatient mental health clinics providing enhanced services to seriously and persistently mentally ill adults and seriously emotionally disturbed children. These Article 31 clinics, which have been designated as Comprehensive Outpatient Programs or COPS clinics, receive provider-specific supplemental Medicaid reimbursement in addition to their base Medicaid rate. Initiated by the State when OMH was required to cease net-deficit financing of its clinic services, COPS has since evolved into a complex funding stream that segregates mental health clinics into two groups, based upon whether or not clinics receive supplemental COPS payments.

An examination of the COPS program and a thorough evaluation of the base Medicaid rate for all outpatient mental health programs are necessary steps in the process of improving the efficiency of mental health funding streams. The upcoming legislative hearing process will provide a forum in which to discuss and evaluate the numerous, existing mental health funding mechanisms.

Innovation

At the state level, funding is distributed through a number of agencies including the Offices within DMH, the Departments of Education, Health, and Labor, the Offices within the Department of Family Assistance, the Office for the Aging, and the Division of Housing and Community Renewal. There is little coordination between state agencies resulting in a wasteful, fragmented service delivery system. Development of flexible and/or blended funding options, such as the Children's Coordinated Services Initiative, would move the system to more efficiently meet the needs of mentally disabled individuals.

The Centers for Medicare and Medicaid Services (CMS), on August 17, 2004, issued a letter to state Medicaid directors (SMDL # 04-005). CMS expressed its continued support for states to implement the principles of money follows the person (MFP). According to SMDL # 04-005:

> ". . .the term 'Money Follows the Person' refers to a system of flexible financing for long-term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change. It is a market-based approach that gives individuals more choice over the location and type of services they receive. A system in which money follows the person is also one that can incorporate the philosophy of self direction and individual control in state policies and programs."

CMS anticipates that as individuals have greater choices in service delivery, a smaller proportion will choose institutional care. "For individuals to naturally select community services over institutional services, states must ensure that a broad array of quality services is provided under a long-term care system that recognizes service delivery options that are diverse and flexible."

CMS identified some promising practices in home and community-based services including one in New York and one in Michigan. These examples illustrate that innovative, entrepreneurial approaches can be developed and adapted to meet the needs of the mentally disabled in the community.

The Visiting Nursing Service (VNS) of New York established VNS CHOICE, a managed long-term care program providing services to older adults with long-term care needs who wish to remain in their homes. In this program, care managers provide skilled home health services and work with both medical and long-term care service providers to coordinate a member's total medical care. The program's care management model uses an interdisciplinary team approach to meet the wide variety of needs that frail, chronically ill older adults often have. According to program staff, VNS CHOICE has reduced hospital and nursing home utilization and improved the appropriateness of medication utilization among members.

The State of Michigan, addressing the issue of increasing access and choice through person- centered planning, combined several funding sources in its contracts with local community health agencies, which serve people with developmental disabilities, mental illness, and addiction disorders. To ensure access and improve choice, the contracts require that local agencies offer a wide array of services and use a person-centered planning process to determine a person's service plan. This model has been successful in improving access to services and reducing costs.

Beyond the promising practices identified by the CMS, the Corporation for Supportive Housing (CSH) has proposed expansion of supportive housing opportunities for the mentally disabled by combining a state-backed mortgage program for OMH non-profit agencies with federal Low Income Housing Tax credits to leverage equity and spur construction of community-based beds. This initiative would speed-up time frames to establish supportive housing opportunities. While initially focusing on the need for homeless housing, this financing construct could be utilized for other types of supportive housing for the mentally ill.

In 2004, the New York State Association of Homes and Services for the Aging (NYAHSA) issued an Adult Care Facility Finance Reform Proposal. According to NYAHSA, this proposal would enable adult care facilities to improve the residential programs for SSI recipients, many of whom are persons with mental illnesses, reduce the need for inappropriate placements in high cost nursing homes and save the State a minimum of $20 million per year. It is apparent that innovative models can be developed and adapted to provide comprehensive, coordinated responses to the needs of the mentally disabled.

Reinvestment

Chapter 723 of the Laws of 1993 created the Community Reinvestment Act (CMHRA). The Legislature determined that the reinvestment of resources accrued from the downsizing of state operated facilities into community-based services would provide a funding mechanism for a comprehensive system of delivery in communities throughout the State.

In 2001, the Executive allowed the CMHRA to expire, removed additional resources from the mental health system, and vetoed attempts by the Legislature to re-establish a reinvestment initiative. In spite of the diversion of hundreds of millions of dollars from the mental health system, state dollars that were reinvested into the communities provided local governments and providers with resources to expand existing programs and establish flexible programs and services to meet identified local needs.

Much of the progress attained by this initiative is in jeopardy as the State continues to seek to maximize federal Medicaid funding through such mechanisms as PROS. Resources, previously funded 100% by State dollars, which provided needed flexibility at the local level, are being removed and replaced with more restrictive Medicaid funding. Non-traditional programs such as peer run clubhouses, programs that serve non-Medicaid eligible persons, including veterans, and initiatives like the CCSI are facing fiscal pressures as a result of this policy.

In 2003, the Legislature enacted the Community Mental Health Support and Workforce Reinvestment Program, which added a new Section 41.55 to the MHL (Part R2 of Chapter 62 of the Laws of 2003). The legislative intent and findings of this legislation states:

> "Since the implementation of the Community Mental Health Reinvestment Act of 1993, the Legislature has found that the availability of a wide range of community-based services has enabled many persons who otherwise might be permanently institutionalized to return to their community and has allowed the State to reduce its longstanding reliance on state inpatient care for persons with mental illness.
>
> "The Legislature has also found that it is important that services provided at the local level be coordinated and resources equitably distributed throughout the State based on local comprehensive plans developed pursuant to the provisions of Section 5.07 of the Mental Hygiene Law."

The provisions of Section 41.55 of the MHL establish a floor of $70,000 per bed closed and require the OMH to annually provide the methodology for calculating per bed costs at state operated facilities. In addition, the OMH was required to submit a long-term plan for the future uses of all state mental health facilities by October 1, 2004 and annually thereafter. This plan, consistent with the provisions of Section 5.07 of the MHL, would identify any proposed facility closures or consolidations and include the related amount of State general fund reductions which could be used for community reinvestment.

On November 3, 2004, the Commissioner of the OMH reported that the full annual closure savings for adult non-geriatric beds in the 2005-06 Executive Budget recommendations is $71,000 and $125,000 for children's inpatient beds. The figure for adult non-geriatric beds may be underestimated since the October 31, 2002 Assembly Mental Health Committee report reflected a per bed cost of $80,000 in 1993, based on an internal memorandum from the OMH to the Division of the Budget. As of the date of this interim report, the Legislature has not received the long-term facility use plan that was required on October 1, 2004.

The OMH continues to operate 17 adult inpatient facilities throughout the State. While the configuration, distribution and future roles of state operated facilities will be determined as part of the state mandated planning process, it is imperative that these facilities be operated efficiently. A review of overtime spending at these facilities revealed that in 2002-2003, over $35 million was spent on overtime. Pilgrim Psychiatric Center (P.C.) had the highest expenditure at $6.5 million, while St. Lawrence P.C. had the lowest rate at $241,000. Using a per bed analysis, Middletown P.C. ($12,027) and the Greater Binghamton Health Center

($10,672) spent the most on overtime. Reduction of overtime expenditures can free up resources that could be used for community-based programs and services.

Cost Analysis

Analytical tools must be utilized that can better assess the effectiveness and efficiency of state operated inpatient facilities. A report entitled, Cost Analysis of Inpatient Hospitalization was issued on August 20, 2003 by the Finger Lakes/Southern Tier 10 County Mental Hygiene Directors, a regional construct of rural county representatives that seeks to work together to address mental hygiene needs efficiently. The report stated that the cost of inpatient hospitalization, whether public or private, represented the greatest share of Medicaid expense to their rural healthcare setting. In examining inpatient cost, they found that using the health industry standard "cost per bed day" (CPD) has limited usefulness in the public mental health arena. Certain variables are artificially set and externally controlled. The CPD does not evaluate length-of-stay as a criterion for effectiveness and efficiency. It discourages bed turnover as it results in "vacant days." Finally the CPD methodology is not reflective of managerial efficiency in that it does not reflect the need for access to state inpatient services in the local "fabric of care." It may reward long stays and encourage denial of access, rather than rewarding efficiency and the ability to serve the maximum number of persons in need of an episode of inpatient care within the allocation provided by the taxpayers.

Other Resources

If the downsizing of the state operated inpatient mental health system continues, a valuable human resource will be freed up to work in community-based settings. State workers impacted by the downsizing of these facilities can provide significant contributions in state operated programs as part of the continuum of services in an integrated comprehensive system. How to best utilize this valuable human resource is a question that needs to be addressed.

There are capital resources available statewide, including vacant or under utilized buildings owned by the State, local governments, and, the private and non-profit sectors. These buildings and lands might be utilized to provide community-based residential or operational space for program development. The feasibility of establishing a number of small, geographically distributed state operated inpatient units for non-geriatric adults should be explored. They could provide a valuable resource in the service continuum in regions of the State with insufficient inpatient capacity. They could also receive Medicaid funding, which would allow for more reinvestment of state dollars into community-based programs as inpatient units in large state facilities are phased out.

State properties that are surplus in the mental hygiene system should be converted to productive uses. Sale of these surplus facilities, or parts thereof, should result in resources, after debt service obligations are paid off, to expand community-based capital programs. This presumes that the State will obtain market value for such surplus properties.

Where state properties are in proximity to community settings, surplus lands and buildings should be separated from the state facilities. They could be converted into community-based residential and service programs and would be eligible for federal funding. This would mitigate objections by federal officials that state operated residential facilities on the grounds of psychiatric centers are just an extension of the inpatient programs and thus not eligible for Medicaid funding. A case in point is the Pilgrim P.C. The community surrounding Pilgrim P.C. is rapidly developing. Pilgrim has already sold some of its surplus land for community development. Community services, such as shopping, entertainment and health care, are becoming readily accessible to the Pilgrim P.C. grounds.

One resource that is often overlooked is the impact of employment on persons with mental disabilities. People who are employed contribute to the tax base. They are contributing members of society and use high cost services less frequently than unemployed individuals with mental disabilities. The President's New Freedom Commission Report, *Achieving the Promise: Transforming Mental Health Care in America*, noted

that a majority of adults, even those with serious mental illnesses, want to work, but are held back by poor access to effective job supports, incentives to remain on disability status, and employment discrimination.

William DeVita, Executive Director of Rehabilitation Support Services, Inc. and Co-Chair of the Resources Committee, presented testimony regarding employment to the Assembly Mental Health Committee in 2003. Following are some excerpts from his testimony.

> "The 'three-legged stool' model which includes housing, services, and jobs is increasingly seen as the formula for successful outcomes for people who face significant challenges to achieve recovery and self-sufficiency. . .The benefits of employment extend beyond the working individual's satisfaction. Employed residents leave transitional Community Residences for permanent housing faster and are hospitalized less frequently and for shorter duration. And, according to recent studies, people with serious mental illnesses who are working consume 50% less mental health treatment services than those who are not working. . . .
>
> "There is a trend throughout the country, for an increasing number of mental health and homeless housing agencies to develop vocational services. . .to provide work opportunities for their tenants or consumers. . . .A partnership between the voluntary sector, mental health consumers, and OMH can make great strides towards vastly improving the employment rate among people with mental illness in New York State. . . .
>
> "The voluntary sector needs incentives and tools to increase the rate of employment among their consumers. OMH can take a leadership role in working with providers to develop, document and disseminate effective strategies for increasing employment. . . .The involvement of consumer groups in every step of the process of implementing this program will be critical to ensure that the programs and services implemented are effective and responsive to consumer needs and interests. . . .
>
> "The funding models utilized by OMH to develop and support the operation of thousands of community residential beds were extraordinarily successful in achieving rapid development targets which resulted in dramatic, positive outcomes for individuals and families. A similar OMH employment initiative which combined with a 'one-stop-shop approach to funding with strong performance standards would enable community agencies to rise to the challenge with the same dedication and tenacity that they have demonstrated as housing developers. . .
>
> "Such an initiative would represent a major stride forward to meet the interests and needs of consumers to choose, get and keep jobs. . . .By implementing this structured program, OMH will provide the opportunity and the strategic resources needed for providers to develop this capacity."

Recommendations regarding Resources:

1. Fully reinvest state savings resulting from the downsizing of state operated facilities and the conversion of programs to Medicaid funding into the mental hygiene system.

2. Phase resources removed from the mental hygiene system over the past ten years back into the system to restore its stability.

3. Ensure that state employees impacted by the downsizing of state operated facilities have the opportunity to contribute in state operated programs as part of a comprehensive, coordinated system of service delivery.

4. Simplify funding streams and enhance flexible use of funding.

5. Provide resources for innovative residential initiatives including: therapeutic foster care for adults; long-term residential group home programs; and, highly structured intensive transitional programs for individuals moving from acute or state hospitals into community placements or home.

6. Align incentives and funding to facilitate successful outcomes in the least restrictive and most effective settings.

7. Staffing levels at OMH inpatient facilities should be reviewed to facilitate a reduction of overtime expenses.

8. Cap local share requirements as segments of the system shift to Medicaid funding.

9. Allocate resources to facilitate staff recruitment and retention in voluntary agencies.

10. Fund and implement demonstration projects that provide employment and related supports to persons with mental illnesses.

V. CONCLUSION

This report contains numerous recommendations to restructure the mental hygiene delivery system in New York State. While several of the recommendations in this report would improve the efficient use of resources, thereby saving public dollars, other recommendations would require an increase in public expenditures. In many cases, such increases in funding would help prevent or eliminate the need for more costly services in the future.

In response to the recommendations contained in this report, a series of public hearings will be conducted by the Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities in order to obtain broader public input. Specific legislative and budgetary recommendations based on the input received and the feedback from the Committees of the Task Force will follow. Completion of a final report of the Mental Hygiene Task Force is anticipated in the fall of 2005.

VI. APPENDIX

A FINAL REPORT OF THE GOVERNOR'S SELECT COMMISSION ON THE FUTURE OF THE STATE-LOCAL MENTAL HEALTH SYSTEM NOVEMBER 1984

In 1984, former Governor, Mario Cuomo, convened a Select Commission to review the efficacy of the State's mental health system and delegated the Commission a threefold charge:

1. Recommend a restructuring of mental health services to better meet the needs of the mentally ill and those at risk of mental disability;

2. Develop improved mechanisms of financing mental health services;

3. Redefine the functions of state and local governments to improve the types of services provided, and their delivery and coordination.

The Select Commission's report, ". . . .is an analytical document that proposes reconstruction of the state's public mental health system - its services, finance and governance - so that individual patients may receive better care." The report identified a number of key problems and issues that hindered the development of a comprehensive system of service delivery. Prior to deinstitutionalization, there was a division of responsibility between the state and local governments. The failure to reconstruct this division of responsibility contributed to extensive fragmentation in the areas of:

- priorities and goals
- planning and management
- funding
- accountability
- service systems

The report went on to state that New York's web of finance service systems and government relationships, burdened with 30 years of incremental changes, did not encourage but often prevented care for those in need. This is not a consequence of neglect in caring or even resources, but rather a persistent failure to effectively coordinate the state and local sectors.

The Select Commission recognized that planning requires a clear vision of what is needed; yet, planning in New York's public mental health system has been generally limited to short-term budget planning. The critical relationships between the mental health and other human service agencies (e.g., health, housing, mental hygiene, aging, education and social services) have not been sufficiently developed. The Select Commission recommended that mental health services planning should be restructured as a population-based planning process closely coordinated by OMH and each local management.

The OMH would, with local input, have the responsibility for defining the service system. Local managements would identify service needs and gaps, and develop an annual area wide services plan, subject to approval by the OMH and utilized at the local level to determine the appropriate services configuration, within the total resources available. At the state level, plans from all local managements would be merged and used to develop budget requests and set department priorities.

The Select Commission identified a number of principles that would lead to a viable system of service delivery for persons with mental illness. These principles included:

- Development of a continuum of services that include effective linkages among public mental health systems to foster continuity of care.
- Integration of public mental health services with health, mental hygiene, education, aging, housing and social services programs.
- Consolidation of funding and management through local managements to ensure a single focal point of fiscal, programmatic and administrative control and accountability.
- Planning for local participation under overall state policy.
- A process to ensure that only those programs that meet real needs, provide quality care, and that can demonstrate their effectiveness be supported by public funds.
- The mental health system should be administered in each region (county or combination of counties) by a local management entity, which may be sponsored by the State, by a local government, or by a not-for-profit organization. The essence of this approach is to firmly establish patient accountability with a local management. The local management cannot be a direct service provider, but must be accountable solely for system management.
- The public and private employee work force should be guaranteed job continuity.

The Select Commission determined that OMH's functions as service provider, regulator and community services manager must be separated. There is an inherent conflict of interest in being both the regulator and a service provider. For example, OMH exempts itself from certain regulations as a service provider creating an

uneven playing field for providers who are required to follow such regulations. This is true at the local level, as well. The select Commission felt that providers of services would relate better to a local management that was not a competing provider.

The Select Commission's report concluded that the state, local government and voluntary provider sectors had assumed, more by accident than by design, different responsibilities, resulting in a lack of accountability, which had become lost and diffused among thousands of different care providers. By finally addressing these structural conflicts honestly and pragmatically, a coherent, accountable system of local management would emerge, enhancing the chances for achieving a richer, more humane service system.

The Select Commission concluded that a comprehensive, integrated system must guarantee that:

1. The mentally disabled patient is the focal point. Therefore, the management organization providing services, funding streams and the system of accountability must all revolve around the individual's needs and well-being.

2. A broad range of care is available on an intermittent and long-term basis, for life, if necessary.

3. Direct mental health care is part of an integrated range of health, social service, housing, and legal services necessary to sustain the mentally disabled.

4. The system integrates state and local government and voluntary, institutional and non-institutional providers.

5. Organization and funding of services, while structured, are flexible to reflect the changing manner in which the needs of the mentally ill are manifested, and the fact that social, political and economic influences themselves constantly change and affect the mental health care system.

While the Select Commission's report focused on the mental health system, many of these same issues are impacting the mental hygiene service delivery system twenty years later. Planning continues to be budget driven with little relationship to local needs and resources. A lack of coordination and integration of services between the Offices within DMH and other human service agencies has resulted in a fragmented system of service delivery which, too often, ignores all of the needs of mentally disabled individuals, fosters gaps in services to the multiply disabled and underserved populations, limits access to appropriate services, and results in a lack of accountability in outcomes for both the service delivery system and the individuals being served.