FINAL REPORT

of the Governor's
Select Commission
on the

Future of the State-Local Mental Health System

November, 1984

Jerome M. Goldsmith, Ed.D. Chairman

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GOVERNOR'S SELECT COMMISSION ON THE FUTURE
OF THE STATE-LOCAL MENTAL HEALTH SYSTEM

44 Holland Avenue, Albany, New York 12229

Mario M. Cuomo
Governor

Jerome M. Goldsmith, Ed.D.
Chairman

November 14, 1984

Honorable Mario M. Cuomo
Governor, State of New York
Executive Chamber
The State Capitol
Albany, New York 12224

Dear Governor Cuomo,

On behalf of the Governor's Select Commission on the Future of the State-Local Mental Health System, I am pleased to submit our final report. It represents the product of an intense 14-month effort and integrates the comments received in testimony at several statewide public hearings. Of particular note is the fact that the opinions shared at the public hearings were overwhelmingly favorable, although we did encounter significant disagreement on some of the creative elements of the report. The points of disagreement deserve to be further debated during the process of implementation.

The Select Commission conducted an objective investigation of the fundamental problems facing the public mental health system in New York State. As part of this investigation, we chose to rely heavily on the research conducted by several previous groups which have reviewed and reported on this topic. Our basis for using this information was the recognition of a remarkable sense of agreement throughout these reports on the identification of systemwide problems and issues.

Our process was an open one involving substantial input from public and private sector providers, constituent groups, state and local government, and mental health officials from other states. The document outlines the historic context in which the public mental health system developed in New York and identifies the barriers to service delivery. It is divided into five key areas: services, finance, management, planning, and research and evaluation. In each area, the Select Commission set forth a number of guiding principles and developed a series of practical recommendations to help remove the barriers to service delivery and establish an accountable system of care.

We hope our agenda for change fulfills your expectation of this Commission's work. We believe your directive to seek mechanisms to restructure mental health delivery to better meet the needs of New York's mentally ill has been met. The report will, we trust, assist you in setting a dramatic and progressive future course for the system. It provides a transitional framework for change that will enable you to implement the recommendations in a manner that is both affordable and practical. Full implementation of the report will, in present dollars, result in a 15 percent growth of New York's present $2.3 billion public mental health system over an eight-year period.

The Select Commission is honored to have participated in this historic undertaking. We stand ready to take part in the implementation process.

Sincerely,

Jerome M. Goldsmith

Jerome M. Goldsmith, Ed.D.
Chairman

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*Mr. Wyngaard resigned from the Select Commission effective September 14, 1984.

Acknowledgements

ON BEHALF OF the Governor's Select Commission on the Future of the State-Local Mental Health System, I wish to acknowledge and thank those who participated in the development of this report. We are grateful to the many representatives of the provider and consumer groups, unions, state and local governmental officials and mental health administrators of New York and other states who assisted the Select Commission in its search for solutions to the problems of mental health care delivery in New York State.

Our sincere gratitude is extended to Brian Hendricks, who is currently Executive Deputy Director of the New York State Office of Health Systems Management. Mr. Hendricks served as the first Executive Director of the Select Commission from September, 1983 to January 31, 1984, and has continued to provide excellent assistance throughout the process. The content of the final report is due in large measure to his vision and creativity.

A special thanks to Ilene Margolin of the Governor's Office for her support throughout this process, and that of her staff—Paula Wilson and Cynthia Abele.

The Select Commission is indebted to Steven E. Katz, M.D., Commissioner of the New York State Office of Mental Health, and Mr. John P. Harcourt, Executive Deputy Commissioner, for their assistance and cooperation and for the knowledge and expertise provided through the assistance of key members of their staff: William Morris, Dr. Morris Cohen, Dr. Robert Cohen and Norman Brier. A special thanks to Laurence Klein of the Office of Mental Health, who brought a depth of commitment and a knowledge of mental health issues which proved invaluable to the Commission.

The Select Commission is indebted as well to James J. McCormack, Ph.D. and the staff of the New York State Health Planning Commission, including Edward J. Dowling and William A.C. Brooks. Their knowledge, experience and understanding of issues contributed immeasurably to the Commission's effort. In addition, we wish to thank Dominick Clemente and Shirley Freeman of the Health Planning Commission for their many hours of word processing.

Our appreciation is extended to John A. Talbott, M.D., Chairman of the Mental Health Committee of the Governor's Health Advisory Council and members of his committee, who produced the report "Alternative Futures for Mental Health Services in New York: 2000 and Beyond" upon which the Select Commission was able to build its recommendations.

Our thanks to Sally C. Stout, who in the early stages provided excellent consultative assistance to the Commission; to Karen Roth and Michael B. Friedman of the Jewish Board of Family and Children's Services for their invaluable advice and assistance in the development of the report, and to Ms. Tillie Carlin and support staff at the Jewish Board of Family and Children's Services for their special efforts on behalf of the Select Commission.

The Select Commission offers an expression of deep gratitude to Patricia M. Lanphear for her dedication and for her excellent administrative skills in organizing and coordinating all aspects of the work of the Select Commission. Our final note of appreciation is in recognition of the outstanding role played by James T. Bulger, Executive Director of the Select Commission. His tireless leadership, administrative talent and decisiveness were crucial in guiding the Select Commission throughout a very complex process.

Jerome M. Goldsmith, Ed.D.
Chairman

Executive Summary

I. INTRODUCTION

IN SEPTEMBER 1983, Governor Cuomo established a 19-member Select Commission on the Future of the State-Local Mental Health System, and directed it to "advance solutions . . . that will produce a total overhaul of the system." Specifically, the Commission was given a threefold charge:

- To recommend a restructuring of mental health services to better meet the needs of the mentally ill and those at risk of mental disability;
- To develop improved mechanisms of financing mental health services; and,
- To redefine the functions of the state and local governments to improve the types of services provided, and their delivery and coordination.

To meet the challenge of this broad and ambitious charge, the Select Commission, chaired by Jerome M. Goldsmith, Ed.D., sought the views of a wide range of experts and advocates from New York and other states. It met 13 times between September, 1983 and October, 1984, and also organized nine roundtable discussions throughout the state to obtain views and recommendations of county and city officials, and providers and consumers of mental health services. Eight public hearings were held across the state in September, 1984, at which more than 200 individuals testified.

This prolonged, open and at times controversial exchange of views confirmed the scope and severity of the problems confronting the state's public mental health system. It also revealed the existence of many worthwhile programs in both public and private sectors, and many dedicated professionals whose efforts merit recognition.

The Commission's report, however, is not a compendium of the specific strengths or weaknesses of individual programs or providers. Nor is it simply another treatise on the historical development of mental health care in New York. Rather, it is an analytic 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.

From the outset, the Commission focused on the initiation of short-term actions designed to start the system moving immediately, if by stages, in the direction of the Commission's major long-range recommendations. Consequently, the report not only details problems and offers recommendations, but also presents a plan for early implementation.

From its inception, the Select Commission recognized that the fundamental problems of New York State's public mental health system were well known and well analyzed. It also recognized that a vision of an ideal community mental health system has been articulated with reasonable clarity and great frequency. What was and is still missing is a specific plan of how to get from the problem-ridden public mental health system of today to a future system which will provide the essence of the vision of community mental health.

II. KEY PROBLEMS AND ISSUES

THE FUNDAMENTAL PROBLEMS of the current mental health system, it is generally agreed, are not flaws in the vision of community mental health but outgrowths of the faulty strategy that was chosen to implement this vision. They are results of a policy of deinstitutionalization which was implemented badly.

What went wrong? And what are the problems we must overcome so that New York can begin to move in the right direction?

The problems are incredibly complex. This fact was made clear repeatedly during the process of the Select Commission's work. But it is still possible to highlight the major thematic concerns which have been repeated so frequently since the results of deinstitutionalization became clear.

A. There has been insufficient funding in the community to meet the needs of patients no longer cared for in state psychiatric facilities. To use the common slogan, the funds did not follow the patients from the institution to the community.

   Of course, this is a simplistic analysis of the current system; and as often as it has been voiced by the advocates of mental health services in the community, other advocates have argued that if the funds followed the patients, the capacity of New York to provide decent, humane, long-term inpatient care would be dangerously eroded. Until now, mechanisms for moving funds to the community while preserving the system's capacity to provide long-term residential care have proved utterly elusive.

B. Prior to deinstitutionalization, there was a division of responsibility between the state and local governments which had worked for over a century. The failure to restructure this division of labor resulted in *extensive fragmentation*:

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

In addition, continued adherence to traditional roles after deinstitutionalization resulted in what is perceived by many as *an institutional bias* in the Office of Mental Health (OMH). OMH has been called upon to oversee, fund, and regulate the total mental health system and to operate the state psychiatric centers. At the very least, this creates a powerful tension between different kinds and degrees of profoundly important public responsibilities.

C. The strategy of deinstitutionalization in New York also failed *to provide for a significant period of transition* from the old institution-based system to the new community mental health system or to *anticipate the need for transitional funding* which would have enabled services to be ready for patients arriving in the community. But, in addition, there was a *failure to anticipate the time needed to overcome fragmentation of perception, of priorities, of vested interests.*

The Select Commission report reflects an effort to address the fundamental problems highlighted above. Our recommendations turn on several key notions, namely:

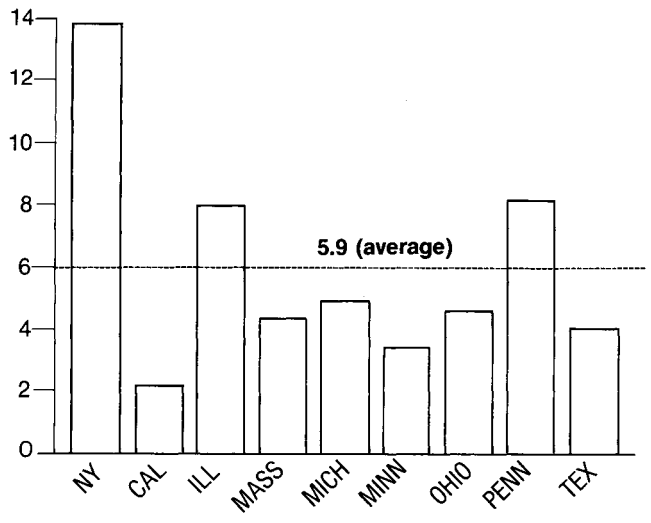
- The achievement of *integration* of priorities, of planning, of management, of funding, of accountability, and of services *through a regionalized public mental health system.*
- The provision of a significant period of transition during which processes of regional reconciliation will be required to establish each region's new integrated structure and *during which the relationship between the local service system and the state psychiatric centers will be recast.*
- The *movement of funds along with patients* while, at the same time, *preserving a capacity for decent, humane, long-term residential care.*
- The *protection* of New York's communities, families and citizens *from the economic dislocation* that would be created by unemployment of mental health workers.
- The *separation of system planning and oversight* responsibilities *from* the responsibility to provide *service through the state psychiatric centers.*
- *Preservation of the diversity and pluralism* of New York's public mental health system *within an integrated framework.* There would be state, municipal and voluntary providers and a variety of regional management models to fit the variety which is New York.
- *Targeting the most needy mentally ill*—those who are chronically dependent on the system for services—with an initial major infusion of funding which will lead to an incremental growth of services *while also assuring a maintenance of effort with regard to the non-chronically mentally ill population.* Ongoing funding for services for both populations would keep pace with inflation.
- The achievement of an *integration of mental health and general health planning* through an expansion of the role and responsibilities of the health systems agencies.

The Commission's discussions with literally hundreds of mental health professionals, providers and families of consumers, as well as the experience and expertise of Commission members themselves, led to the inevitable conclusion that significant changes in the system are essential. New York, historically an exemplar in mental health with the first state hospital and the first community mental health services legislation, no longer holds a clear position of leadership and excellence. Its institutions and programs have not kept pace with the innovation and developments that the 1980s require. Indeed, New York's web of finance, service systems and governmental relationships, burdened with 30 years of incremental changes, often prevents, not encourages, 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.

In the first half of the century, New York's commitment to the mentally ill led to construction of a state hospital network that housed over 90,000 inpatients in 1955. Despite the existence of this massive institutional system, the state welcomed the breakthroughs of the 1950s and 1960s—psychotropic drugs, patients' rights and community treatment—and enacted legislation creating and funding a complex network of community-based public mental health services that support over 2,500 providers today. However, the legacy of the institutional movement continued, although at a reduced scale.

As a result, New York has the nation's largest state hospital system and its largest publicly and privately-sponsored community services system. The former is represented in Figure 1, which compares the number of state-operated inpatient beds in New York with five major industrial states.

FIGURE 1: Number of State Psychiatric Center Patients per 10,000 State Population



Source: Draft Mental Health Report of State Mental Health Indicators by National Association of State Mental Health Program Directors, 1982.

30 years, individual financing mechanisms were added to meet legitimate needs or solve specific problems; taken together, however, they have tended to fragment care and diffuse responsibility, resulting in a complex, often counterproductive financing system. These funding conflicts have been exacerbated by the development of entangled relationships involving local government, voluntary providers and state institutions. Growth of the local and voluntary sectors has been dramatic, but clarification of each sector's responsibilities has not occurred.

The consequence of this failure to clarify accountability and rationalize services falls directly on the mentally ill. The lack of residential alternatives in the community and disjointed and often ineffective treatment are the symptoms. Even now, mental illness is poorly understood, and while treatment is very often effective, there are no real cures for the serious psychotic disabilities—such as schizophrenia. Those directly affected must rely on their families and professionals for care of a disease that can be frighteningly disruptive and often require treatment for many years—for some, a lifetime.

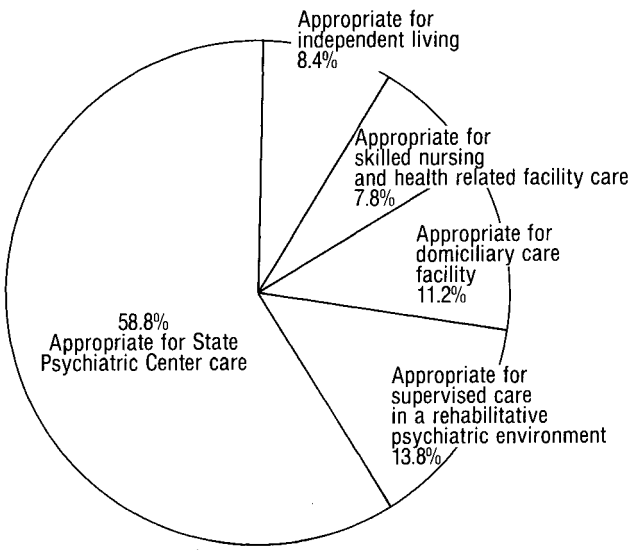
Mental illness is often a chronic disability requiring

The existence of two massive systems with conflicting viewpoints and operating methods poses serious issues affecting patient care. State psychiatric centers provide care at no cost to local government. This encourages inpatient care, even though community services are recognized as the more effective and less costly form of treatment. Recent OMH studies document that 9,000 of the 21,000 inpatients in state psychiatric centers would be better served in the community. Unfortunately, funding shortages and local reluctance to accept and care for mentally ill persons lead to costly, inappropriate care in large institutions.

Figure 2 represents the level of care required by New York State psychiatric center patients in 1983.

Over $2.3 billion is spent annually on New York's public mental health services, with more than 90 percent coming from state and federal sources. These funds are not allocated objectively according to patient needs, but rather too often are a product of restrictive eligibility criteria, the patients' age and financial resources. Some are allocated by local government (local share of state aid), others are based on net deficit contracts (community support services program). Over the past

FIGURE 2: Level of Care Analysis - New York State Adult Psychiatric Center Population - 1983



SOURCE: New York State Office of Mental Health, 1984.

sustained, responsive and appropriate care. Yet there is seldom any effective mechanism to monitor and coordinate the many necessary components of such care for the client. Frustrated by a fragmented financing system, providers and governments too often shift patients within an already strained delivery system to follow the flow of dollars—not to address real patient needs.

Government has a basic responsibility to protect those who cannot help themselves. Annually, almost 500,000 New Yorkers receive some degree of care in the public mental health system, of which more than 80,000 have a long-term serious mental illness. Variations across the state in amounts and types of services available raise a basic concern for equity. A closer examination of the appropriateness of services actually used suggests significant gaps on one hand, and inefficient use of mental health personnel and over-long institutional treatment on the other.

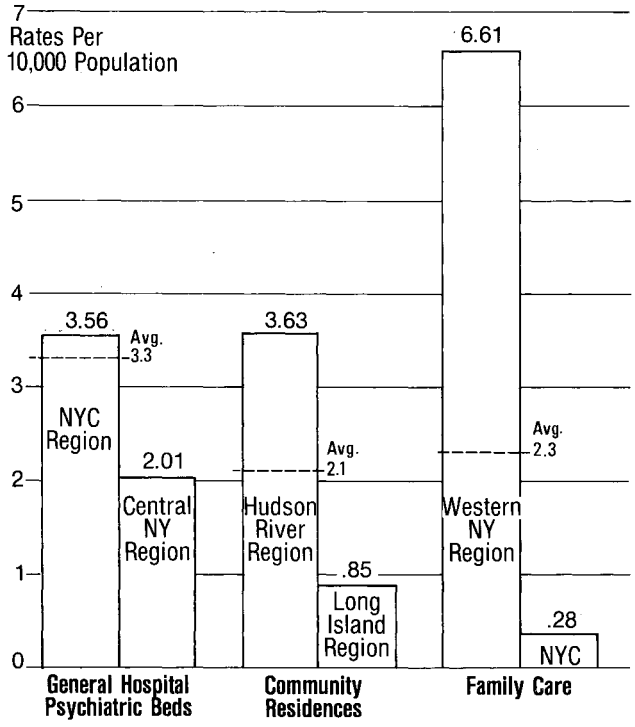
Figure 3 documents the wide variability of inpatient and outpatient services throughout the state.

The system has too many discrete elements. Too often, responsibility for a patient may be interpreted as ending with a single service offered by a provider, although the patient's chronic but changing needs may demand supportive and coordinated long-term care.

Planning requires a clear vision of what is needed; yet, to date, planning in New York's public mental health system has been generally limited to short-term budget planning. Standards to define the essential elements of any effective service system are not in place, nor is an effective mechanism for involving the community in defining its unique service needs. The critical relationships between mental health and other human service agencies (e.g., health, housing, mental hygiene, aging, education and social services) have not been sufficiently developed.

New York's public mental health services vary widely in availability, cost and quality. This state has more psychiatric hospital beds per capita than any other in the country and spends more than any state, yet most experts agree that many critical service needs are still unmet. These gaps are most noticeable in supportive residential alternatives for both adults and children, targeted preventive services, crisis care, and services to minorities. But even were these important programs adequately supplied, the service system would still urgently require a means to coordinate care and link patients with the services they require.

FIGURE 3: Services Variations by Region in New York State



SOURCE: Alternative Futures for Mental Health Services In New York: 2000 and Beyond, Governor's Health Advisory Council, (1984).

III. PRINCIPLES

CONFRONTED WITH THESE compelling problems, the Commission developed a set of operating principles to guide its choice of recommendations. Briefly stated, these principles call for:

- Development of a continuum of services.
- Effective linkages among all public mental health systems to foster continuity of care.
- Consolidation of funding and management through local managements to ensure a single focal point of fiscal, programmatic and administrative control and accountability.
- Formula-based funding consistent with patient needs.

- Planning for local participation under overall state policy.
- A process to ensure that only those programs that meet real needs, provide quality care, and can demonstrate their effectiveness be supported by public funds.
- Integration of public mental health services with health, mental hygiene, education, aging, housing and social services programs.

IV. RECOMMENDATIONS

IN ACCORDANCE WITH its principles, and its understanding of the populations to be served, the Select Commission sought recommendations that would be practical but would address the fundamental needs of the state's residents. Obviously there is need to retain the existing strengths of New York's system, while allowing flexibility to respond to changing population characteristics.

These recommendations have two fundamental purposes—to prevent, reduce, ameliorate or cure mental illness found among the people of New York and to provide the most effective treatment possible to those afflicted with mental disabilities. The Select Commission recognizes the need for three distinct programs: long-term institutional and community-based services to those with chronic disabilities; intensive, accessible but often temporary services to the mentally impaired; and targeted prevention services to those at high risk of mental illness. Each program is an essential component of an effective system of mental health care. The successful fulfillment of these functions requires suitable resources and significant change in New York's present public mental health system.

It is evident that no single course of action, whether in financing, management or services, will solve present problems. What is needed is a comprehensive restructuring that will bring about intensive, long-term changes in all the key elements of public mental health care: services delivery, finance, management, planning, and research and evaluation.

The Commission's recommendations for each of these key elements follow.

A. Services Delivery

1. The Office of Mental Health should provide for the local delivery of all basic services, including case management, to the mentally ill.
2. The Office of Mental Health should develop standards to assure appropriate local service configurations, minimum program requirements and effective service outcomes.

A complete spectrum of basic services should be readily available throughout the state, including; crisis services to include mobile crisis outreach; acute, intermediate and long-term hospital care; special needs housing; non-residential alternatives (day and continuing treatment, psychosocial clubs, etc.); clinic services; prevention and education programs; and case management.

Consistent with a regional service plan, new services should be developed to meet critical needs. In many areas, the initial focus would be on crisis intervention services and additional community residential settings to lessen the need for inpatient care. At the local level, patient-specific treatment plans which must be systematically monitored and evaluated will be critical components of such care. A strong and effective multi-level case management system is proposed to insure coordination of services and the provision of necessary care to the mentally ill of the state. A major component of case management will be a client tracking and monitoring system that will provide reliable and updated information on the progress of all patients throughout the service system.

New staff recruitment and training policies should be implemented to more effectively reach minority clients.

The Office of Mental Health should establish population and program standards based on sound needs assessment methodologies to determine the kinds and quantities of services required locally. While maximum local flexibility would be given to develop the appropriate array and configuration of services, they would be firmly based on criteria reflecting population characteristics and would be deployed to assure equity throughout the state.

B. Finance

3. For finance purposes, the population using the public mental health system should be divided into three separate groups, with appropriate definitions and eligibility criteria for each.
4. Funding of services provided in the public mental health system should be simplified and allocated locally to effectively address the needs of the mentally ill population.

5. The state should provide necessary fiscal incentives and establish a capitalization assistance program for the acquisition, renovation and construction of facilities to expand special needs housing and community-based services for the mentally ill.
6. The Office of Mental Health, with the State Departments of Health and Insurance, should promote the expansion of private mental health insurance coverage.

To more rationally target the expenditure of over two billion dollars currently spent in the public mental health system in this state, the population utilizing services has been divided into three separate groups, with appropriate definitions and eligibility criteria for each. These categories are not meant to restrict any patient's access to the level of care required nor should any stigma result from these funding categories.

The first population group, the current long-term population, will consist of patients requiring the services and environment found in either a state psychiatric center or a licensed family care home.* All individuals who have continuously resided in either setting for a defined period of years, to be determined by a special panel of clinical experts, will be considered part of this population I and will continue to be financially supported by the present combination of state, Medicaid and Medicare funding. For purposes of financing only, this population will be established as a discrete group on a fixed date to be determined by legislation, and its numbers will not be increased with new patients after that date. This does not imply, however, that new patients, not initially eligible for population I, will not be admitted to state psychiatric centers or family care programs. Rather, it sets up a new funding arrangement in which such patients' care will be financed through the mechanisms described in populations II and III. Population I patients can also be moved into the population II group as they become capable of living outside of inpatient institutional settings.

The system dependent mentally ill—population II—is comprised of those individuals who are seriously and persistently mentally ill, requiring long-term supportive mental health care. These individuals may presently be in a state psychiatric center, although it is more likely that they will reside in the community. This population will consist of individuals who, by clinical assessment, meet criteria in each of the following three areas: diagnosis, disability and duration of illness. Individuals of all ages will be eligible for admission to this population. The Commission intends for the local management established in each new region of the state to be held strictly accountable for each individual in this population. The finance recommendations are intended to provide local managements with a means of carrying out this new and critical responsibility.

The recommendations are meant to expand the scope of services available, finance them at 100 percent state cost (less federal and third-party reimbursement), improve the mental health services available to persons residing in nursing homes and health related facilities, and move patients to the most appropriate settings in which they may receive proper care. In addition, they will help us realize more fully the goal of the dollar following the patient.

As a first step, several of the multiple funding streams should be consolidated, including Medicaid, State Purpose, Community Support Services and 620 and 621. Following this consolidation, and based upon the success of demonstration efforts, the Office of Mental Health should move to a system of prospective financing (capitation). The aggregate dollar amount budgeted in advance for each region in the state will be calculated principally on the numbers and characteristics of those individuals in population II. The key advantage of this approach is that it determines in advance an allocation to each local management of the total public resources to insure a comprehensive range of services. This initial aggregate amount should be at least equal to the current funding now available from the present multiple funding sources. The critical difference in this proposal is the linkage between the fixed areawide funding levels and the service responsibilities of the new local managements. This will reinforce *accountability,* meeting all of the service needs of the patient. The local managements will utilize these funds to assure that appropriate services are provided to population II clients. Contracts between the local managements and community-based and state psychiatric center providers will be the mechanism for distribution of dollars. For example, the local managements will reimburse state psychiatric centers on a per diem basis for care rendered to patients in this population. Funding will also be made available to augment the mental health services available to residents of skilled nursing facilities and health related facilities.

*Note: A licensed family care home is the combination of a private residence and a family certified by the Commissioner of the Office of Mental Health to provide care to no more than 10 mentally disabled persons.

Population III, the periodically served, will consist of those individuals who intermittently use the public mental health system of care or are at risk of becoming mentally ill. There will be ample flexibility to allow for the movement of individuals in population III, who ultimately meet the eligibility requirements, to population II. The provision of necessary mental health services to population III, including but not limited to crisis care, clinic, day treatment, partial hospitalization, education, prevention services and targeted case management services, should be financed through formula-based per capita grants to each local management. The per capita grants should be based on a total area population adjusted for key factors such as income, population density, race, age, transportation problems, etc. The various forms of funding for this population group would be superseded by this method. The per capita grant formula approach should be established by state law to assure that funding levels change with inflation and changing population dynamics. The local match requirement will be essentially continued. The wide range in current state aid per capita will require several years to modify to attain reasonable statewide equity.

Recognizing that one of the major impediments to the expansion of the community-based care system is securing financing for the acquisition, renovation or new construction of necessary facilities, a capitalization assistance program is proposed that will consist of several different funding mechanisms. Included are bond issues, a mortgage guarantee pool, a revolving loan fund and direct grants. It is hoped that this finite pool of state capitalization monies will leverage the greatest private financial participation.

Lastly, the Commission agrees that the present state statute which excludes mental health care as a required component of full private health insurance benefit packages should be examined for possible revision. This examination should be conducted by the State Departments of Health and Insurance, the Office of Mental Health and an interdisciplinary panel representing local government, the voluntary sector, patient advocates and the health insurance industry.

C. Management

7. The Office of Mental Health should be reorganized and assigned responsibility for direction of the statewide public mental health system.
8. The mental health system should be administered in each region by a local management, which may be sponsored and operated by the state, by a local government, or by a not-for-profit organization.
9. The public and private employee work force should be guaranteed job continuity and employment opportunities in the expanded community-based system of mental health care.

Restructuring of the public mental health system for more efficient care and treatment must begin at the state level through reorganization of the Office of Mental Health. OMH's functions as services provider, regulator and community services manager must be separated. The OMH role as the principal source of direction to local systems must be reinforced with a strengthened capacity to plan, set and monitor standards and evaluate the performance of the community mental health system.

Even greater systemic changes must be made locally. In each local mental health region—a county or combination of counties—a single accountable local management is essential. This local management may be a state government sub-unit, a county, or a quasi-public authority composed of state, county or city officials, and voluntary sector representatives.

The process of identifying the appropriate sponsor for a local management will begin with the development of a request for proposal by the Office of Mental Health. Proposals will be solicited from local governments and other qualified bodies, and reviewed by OMH against a variety of objective criteria developed jointly by OMH and a broad range of public and private sector representatives. If local proposals are deemed acceptable, a local management designation will be made. Should a proposal be unacceptable, or in the absence of a local proposal, the state would be designated as the local management. The Mental Health Services Council will play a major role in providing OMH with advice during this selection process. It is expected that local managements will be phased-in on a statewide basis within five years.

Local managements must assume responsibility and be accountable for assuring the delivery of effective mental health care to defined populations within predetermined resource limits. The local management cannot be a direct service provider, but must be accountable solely for system management. The intent of the Select Commission is not to exclude state and/or county governments from becoming local managements, as both are service providers. Rather, it is envisioned that the local management function can be organizationally sepa-

rated from that of direct service delivery. Waivers should be granted by OMH where this separation is impossible. The local managements would contract with local and state providers to deliver services which they determine are needed, and would coordinate such services through careful case management—assessing client needs, developing service plans and ensuring and monitoring delivery of care. The relationship of local managements with OMH and its psychiatric hospitals is a critically important element. This relationship, detailed thoroughly in the body of this report, should be fully articulated in a formal bilateral contract, with the roles and responsibilities of local management and the state clearly described.

Providers—including state psychiatric centers, voluntary hospitals, freestanding clinics and residential programs—would relate to a local management which is not a competing provider, but is responsible for assessment and movement of patients through the local public mental health service network. *The essence of this approach is to firmly establish patient accountability with a local management.*

It is imperative that throughout this process of change, the Governor's Office and the Office of Mental Health take all necessary actions to insure job continuity for employees of state psychiatric centers, as well as local government and voluntary provider employees who may be moved from one auspice to another or from institutional care to community-based care. The state should weigh the broader implications of its proposed systemwide changes on all mental health employees and consider several pilot programs that would ease the deployment of certain workers by providing appropriate training.

D. Planning

10. Mental health services planning should be restructured as a population-based planning process closely coordinated by OMH and each local management.

The Office of Mental Health will, with local input, have the responsibility for defining the service system and determining the minimum and maximum acceptable quantity of services necessary to treat a defined population. Within this framework, local managements will identify service needs and gaps, and develop an annual areawide services plan. This plan will be subject to approval by the Office of Mental Health and will be 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 will be merged and used to develop budget requests and set department priorities. The plan will also include a personnel redeployment plan to insure continuity of employment for all mental health employees in the affected area. The Office of Mental Health will continue to plan for personnel and capital needs at each of its psychiatric centers.

E. Research and Evaluation

11. OMH should be responsible for promoting research and evaluation through its renowned research institutes and other resources.

Basic and applied research into the causes and treatment of mental illness is essential to open new approaches to the future care and treatment of mental illness. Systematic evaluation of community mental health programs is also critically important to establish reliable and attainable performance standards, and to assure appropriate quality standards and regulations.

The heart of these recommendations focuses on defining the financing and management roles for the three populations. Rough statewide estimates are diagrammatically described in Figure 4:

In summary, the Select Commission's recommendations call for changes at both state and local levels. Essentially, they require that OMH provide overall leadership and establish a framework in which local services can be provided with assurance of appropriate quality, access and continuity of care. The local managements would be responsible for guaranteeing availability of an adequate array of services within boundaries established by OMH. The key elements of this proposed system include:

- An area network of providers accountable to local managements under performance standards that assure access and continuity of quality services.
- Financing that fosters accountability by mandating responsibility for all mental health care required.
- A well-defined, accountable local management with responsibility for serving groups at need in its area. Local management is the key to systemwide accountability.
- A well-articulated, budgeted plan specifying who is to be served with what services, and having linkages

Figure 4
The Select Commission's Proposals
Populations, Funding and Key Services

POPULATION GROUPS	FUNDING	KEY SERVICES
Population I Current Long Term Care 8-12,000*	State Purposes, Medicaid and Medicare $500 million** annually	Inpatient care
Population II System Dependent 80,000-100,000*	Capitation (includes Medicaid, Medicare) $1.1 billion** annually	Residential alternatives Continuing clinic care Case management
Population III Periodically Served 400,000*	Per capita grants supplemented with insurance, Medicaid, Medicare, local government funds $400 million annually	Crisis care Targeted prevention programs

*Statewide estimates
**1983 estimated aggregate expenditures

SOURCE: New York State Office of Mental Health

to generic health, social services, mental hygiene, education services and housing providers.

- Research and evaluation to improve systems operations.

V. IMPLEMENTATION STRATEGY

THE SELECT COMMISSION is critically concerned that the initial actions taken toward implementation establish a clear and decisive agenda for reform. An implementation strategy containing several specific steps to be undertaken without delay is recommended for the purpose of assuring that the necessary momentum be developed. The timeliness and success of these actions will enhance the potential for full systemwide reform. Below is a brief listing of some of these activities:

A. Draft and seek enaction of major legislation, a "Comprehensive Care Act for the Mentally Ill," which permits a five-year period for the designation of areas and selection of the local managements across the state and enables the broad range of finance and service changes to become a reality.

B. Substantially increase funding for critically needed services, particularly supportive residential and day treatment services for both adults and children, case management, and initial resources for local managements.

C. Establish at least three capitation demonstration programs.

D. Develop state-operated, local government-operated and quasi-public local managements without delay.

E. Initiate a major reorganization of the Office of Mental Health and develop the tools, plans and services necessary to begin implementing this report's major recommendations.

F. Establish a review panel or use the Mental Health Services Council to evaluate the implementation of the Select Commission's recommendations.

CONCLUSION

THE SELECT COMMISSION recognizes that over 30 years have elapsed since the last major impetus for change in the basic structure of New York's public mental health system. The development of community services, taken as a whole, has fallen tragically short of

promoting equal availability and access to the full range of services necessary for humane care. The state, local government and voluntary provider sectors have assumed, more by accident than by design, different responsibilities, resulting in a serious lack of accountability, which has become rather lost and diffused among thousands of different care providers. Our sincere hope is that by finally addressing these structural conflicts honestly and pragmatically, a coherent, accountable system of local management will emerge, enhancing the chances for achieving a richer, more humane service system. New York's mental health services clearly demonstrate that more than resources, compassion and dedication in helping the mentally ill are necessary.

We are impressed by the widespread recognition of these fundamental systemic problems and the broad consensus on the urgent need for reform. While few may agree now on the specific solutions to be pursued, we are convinced that with the support and efforts of both the executive and legislative branches of state government, the larger mental health community is prepared to tackle the necessary agenda for change and to overcome its fear of moving away from the fragile and inadequate status quo. As the state moves into the initial period of implementation of these recommendations, we must never lose sight of the overriding mission that guides our work—the achievement of a more humane and effective service system for those most in need.

1 Introduction

NEW YORK STATE HAS PIONEERED many of our nation's historic innovations in mental health care. The state led the nation at two critical junctures in mental health care development: the 1890 State Care Act, which was the first state law to establish a centralized statewide humane hospital care system, and the 1954 Community Mental Health Services Act, which was the vanguard of community care. Both laws set the model which the nation followed.

New York State has also been in the forefront of research and has provided treatment breakthroughs in many areas, including the development of psychotropic medication. This medication made it possible for many people formerly confined to lifelong institutions to function in the community.

New York State's innovative history in mental health care provides a legacy for its future. While past major innovations in mental health care involved assigning major responsibility to either the state (in 1890) or local sector (in 1954), the next major breakthrough, as proposed in this report, involves the cooperative efforts of both the state and local sectors.

The metaphor—"The Family of New York"—often employed by Governor Cuomo must be applied to the public mental health system. The state and local systems must be brought together as a family to provide care.

We must begin by acknowledging the following:

- For approximately 80,000 chronically mentally ill individuals, there is presently no known cure for their disability. Progress can only be made in controlling and stabilizing their illness. In accepting the likelihood of lifetime care, we need not abandon them exclusively to institutions. There are many interventions that allow a disabled person to make the transition to community life, if not forever, then at least for protracted periods of time. By identifying those functional 'deficits' or 'pieces of behavior,' if you will, that make it impossible for a patient to live in the community, specialized treatment plans and supportive services can be applied that enhance the person's potential for living outside of institutions and even for learning to adapt to independent or semi-independent living.
- The care needed for a chronically ill person includes:
  - —clinical treatment which works in partnership with the family and friends of the patient;
  - —case management services;
  - —an appropriate residence;
  - —rehabilitative services and supportive work activities.
- These four elements of comprehensive care—clinical treatment, case management, residence, and rehabilitation—are all the business of the public mental health system.*
- Continued enhanced research provides the best possibility for a breakthrough in the treatment of mental illness.

In Governor Cuomo's first address to the State Legislature on January 5, 1983, he stated: "Over two decades of deinstitutionalization have dramatically decreased the census of psychiatric centers . . . But the price of this effort has been a confused array of conflicting and costly programs. To chart a course for the 1980s and to achieve a balance between state and local government responsibilities, I shall establish a Select Commission on the Future of the State-Local Mental Health System—a Commission . . . that will advance solutions . . . that will produce a total overhaul of the system."

The Governor signed Executive Order No. 24 on September 20, 1983, which established the Select Commission on the Future of the State-Local Mental Health System. Its charge was to systematically review the traditional roles and responsibilites of the state, local government and other service providers, to develop policy options to improve coordination of various programs and to evaluate alternative fiscal mechanisms to facilitate a comprehensive restructuring of service delivery and relationships.

As part of the mission, the Governor directed that a subcommittee develop immediate recommendations to ease the overcrowding of New York City acute inpatient psychiatric beds. In December 1983, the Subcommittee on the New York City Psychiatric Bed Crisis submitted to the Governor 16 short-range, concrete proposals for easing the problem by specific actions intended to increase the availability of acute beds where needed the most, facilitate the transfer of patients to more appropriate settings, expedite the opening of community residences and day treatment programs, more adequately address the specialized needs of the homeless mentally ill, and promote the integration of providers and clinicians into a more coherent system of care

*Throughout this report, the term 'public mental health system' refers to the wide range of government, voluntary and proprietary organizations which are licensed, certified and/or funded by the Office of Mental Health to provide mental health services. The term public mental health system does not include private practitioners, the Veterans Administration or other programs not subject to supervision by the Office of Mental Health.

(see Appendix F). Many of these recommendations were incorporated in the Governor's subsequent State of the State Message and the 1984-85 Executive Budget and have already begun to be implemented.

The Select Commission, composed of 19 members representing a broad range of public and private sector interests, followed a very intensive schedule of meetings since September 1983. The Select Commission also conducted a very open and inclusive process for involving and considering the many aspects of the public interest.

Seeking guidance from the broader human service field, the Select Commission was addressed by two former Commissioners of the Office of Mental Health, the New York State Health Planning Commission, the Consortium of New York State Health Systems Agencies, the New York State Departments of Social Services and Health, the Office of Mental Retardation and Developmental Disabilities, and the Commission on Quality of Care for the Mentally Disabled. Speakers from the Monroe/Livingston Demonstration Project, the Conference of Local Mental Hygiene Directors and various city and county programs provided a valuable community perspective to the issues at hand.

The experiences of several other states, especially California, Missouri, Pennsylvania and New Jersey, were also explored. Presentations by key state and local government policymakers from each of these states were given to the Select Commission. A full list of individuals and organizations from which information was sought by the Select Commission appears as Appendix D.

To provide a forum for open public dialogue on issues and problems, the Select Commission sponsored a series of nine roundtable discussions—in New York City (3), Long Island, Eastern New York, Central/Western New York, the North Country, and the Southern Tier (2). These discussions, attended by representatives from the Select Commission, local mental health agencies, community providers, state psychiatric centers, mental health advocacy organizations and community organizations, provided the Select Commission with valuable insights into local concerns.

To address specific problem areas and work toward developing recommendations, the Select Commission organized itself into three subgroups or panels—services, finance and governance—which met and deliberated between full Select Commission meetings. Each panel membership included individuals with special expertise in its subject area. The work of these panels led to the preparation of preliminary reports and ultimately to the principles articulated in chapter IV of this report.

Throughout the exploratory and developmental process of its work, the Select Commission has enjoyed the encouragement and support of the Commissioner of the New York State Office of Mental Health, Dr. Steven E. Katz, and his staff.

This report of the Select Commission is organized into six major chapters. Following this introductory chapter, chapter II provides an historical context for our deliberations. chapter III explores the barriers and deficiencies of the present public mental health system in New York State. There follows in chapter IV an articulation of the principles of the Select Commission which act as a framework for the development of the specific recommendations contained in chapter V. This chapter, organized into two subsections, presents the constraints viewed by the Select Commission as the parameters within which realistic limits for developing recommendations were set, and a listing of specific recommendations. chapter VI is an implementation strategy identifying specific actions to be taken over a course of time. This strategy is designed to set forth the precise steps needed to implement the recommendations.

Prior to the presentation of this report to the Governor, the Select Commission worked with the Office of Mental Health, the Division of the Budget and legislative staff to design the strategic plan for implementing recommendations for change. During September, 1984, eight public hearings were conducted throughout the state to solicit input from the public on the final draft of this report. Subsequent to these public hearings, the report was reviewed, revised as deemed appropriate and approved by the full Select Commission. Appendix C identifies several aspects of the report that were revised as a result of the public hearing process. A Governor's Conference on Mental Health held in November, 1984, began the long process of reaching consensus on the major recommendations among all interested parties. It is anticipated that a timetable for implementation, including new legislation, will be set in motion following the conference.

Among the important subjects to be discussed at the conference, with legislative leaders present, will be the Select Commission's proposed enactment of a "Comprehensive Care Act for the Mentally Ill" which advances and pioneers care in the tradition of the 1890 and 1954 legislation mentioned earlier. The act would incorporate the four points made on pages 2 and 3 and include incremental funding increases for required services. This act, to be developed using the recommendations contained in this report, also assures clear and definitive accountability for the provision of care. The state must redesign the methods for organizing and funding mental health care. First and foremost, the redefined system of care proposed will insure treatment and fiscal accountability for the individual mentally ill patient. Those most in need of care, whatever their age or disability, should no longer be shunted aside or overlooked.

Effective care will be provided on a long-term basis and will be organized so as to allow maximum flexibility and creativity at the local level. That flexibility will occur within the parameters set by state regulations but will acknowledge the diversity required in a state as large and complex as New York. To these ends, the "Comprehensive Care Act for the Mentally Ill" will set

in motion the following management, governance and fiscal innovations:

- Full participation of providers from the state, local government and voluntary agenices, including short stay acute hospitals, in local management, in development of local regional plans and in direct provision of care;
- Full participation of consumers, their families, advocates, citizen leaders and local government in the planning and monitoring of care;
- Opportunity for alternative approaches in the organization of services to respond to unique local characteristics;
- Introduction of simplified, patient-oriented funding mechanisms that will provide incentives for cost-savings in the delivery of care and will reach all those who need such care;
- Clarification of the many needs of the mentally ill and of the expectations for service providers in meeting those needs; and
- Commitment to capitalize on the state's leadership in research and evaluation by enhanced support for those programs and full integration of those activities into the daily care provided for the mentally disabled.

The standards and proposals contained in this report are bold, but pragmatic. They are designed to reflect realistically the complexity of the needs of the mentally disabled and to retain the strengths of the present system, while at the same time redressing the deficiencies. It is a plan which can begin immediately even though bringing it to fruition will require a sustained effort over time. If successful, it will be as precedent-setting as were the New York State Acts of 1890 and 1954.

2 Historical Context

ANY ATTEMPT TO IMPROVE the public mental health services system must include an understanding of the historic context of the provision of service and the evolving philosophies of mental illness and its treatment.

With the passage in 1865 of the Willard Act, New York assumed the cost and administration of care for the mentally ill and began to establish institutions for the insane, relieving local communities of the burden of caring for this dependent population.[1] The State Care Act of 1890, which remained extant until supplanted by a philosophy of community care in the 1950s, was the first law in the nation based on the assumption that a centralized state system could provide a safe environment for mentally ill persons to receive humane care.[2] The advocates of the 1800s envisioned small, rural therapeutic retreats where, through moral treatment or plain talk, mentally ill people would be cured and would become productive members of society instead of drains on the public purse. Actually state hospitals "fulfilled a function for society by keeping the mentally ill out of sight and, thus, out of mind. Moreover, the controls and structure provided by the state hospitals, as well as the granting of asylum, may have been necessary for many of the long-term mentally ill before the advent of modern medications."[3]

As new asylums were built, demand always exceeded capacity. The state hospital population grew steadily until 1955, when over 559,000 patients nationwide resided in state-controlled facilities. The New York State inpatient census peaked in 1955 with 93,000 patients.[1] Most hospitals were badly overcrowded and conditions were often inhumane. Treatment, whether curative or palliative, was limited by available medical technology and the shortage of staff.

In the 1950s and 1960s, mental health professionals began to redefine the purpose of state psychiatric hospitals. Changing attitudes in the therapeutic community championed the cause of community-based mental health care. New York pioneered the trend toward community mental health with the passage of the Community Mental Health Services Act of 1954. The act established community mental health boards in each county and in New York City to, among other things, coordinate delivery of mental health services at the local level. It represented the first involvement of localities in the care of the mentally ill in the state since the 1800s. As an incentive for localities, the state reimbursed community mental health boards for 50 percent of their expenditures, with a cap of $1 per capita of the general population.[2] However, the act did not provide for integration of local services with the state hospital system, and did not establish a policy of community-based alternatives to state hospitals. Instead, care was oriented to early intervention and acute treatment at short stay acute hospitals, the philosophy being that if early and intense treatment could be delivered in a community setting, future admissions could be reduced.

The philosophy, in fact, was sound. Unfortunately, the outcome had little relationship to the intent of its initial design. As a result of this legislation, enormous pressures were placed on a community-based system that was incapable of rendering care to large numbers of patients. More specifically, much of the burden fell upon the short stay acute hospital system. Over time, this burden developed into crisis proportions, especially in New York City, and perhaps, can best be illustrated by the following excerpt taken from the Select Commission's December 1983 publication entitled, Report of the Subcommittee on the New York City Psychiatric Bed Crisis:

- high (short stay) hospital occupancy rates, especially in adult (psychiatric) units (in New York City) commonly exceeded 100 percent;
- (there is) evidence that a significant number of patients are daily waiting admission in emergency rooms; and,
- (there is) inappropriate use of (short stay) hospital beds, due to a lack of access to non-inpatient care—20 percent of all (New York City) municipal hospital psychiatric patients in 1981.

A concomitant development which profoundly influenced mental health treatment at this time was the introduction of psychotropic drugs. The introduction of drug therapy in 1954-55 allowed the control of symptoms so that many patients could be released from institutions. This breakthrough in pharmacology changed the treatment of mental illness and led to an optimistic perception that mental illness could be cured. Because of this mistaken belief, the needs of some patients for lifelong care were not fully acknowledged.

In the early 1960s, other economic, legal and political factors altered the focus of community mental health care. Originally conceived as auxiliary to large institutions, community-based care became a primary care alternative as a result of changing federal policies and a new clinical perspective which was expressed through the deinstitutionalization movement.

A. The Role of the Federal Government

The experiences of World War II demonstrated the success of psychiatric treatment in combat emergencies and led to the first federal involvement in the promulgation of mental health policy.[1] Congressional passage of the Mental Health Act of 1946 and the creation of the National Institute of Mental Health established mental health as a major public health concern. Early federal research and evaluation activities studied the mental health problems, but did not involve funding for the direct provision of services.[2]

In 1955, Congress established the Joint Commission on Mental Illness and Health. The Commission's final report, entitled "Action for Mental Health" (1961), recommended improving institutional care and promoting community-based services. The federal government chose to place full emphasis on funding for community-based care.[1]

In a State of the Union message, President John F. Kennedy criticized "abandonment of the mentally ill and the mentally retarded to the grim mercy of custodial institutions."[1] In 1963, two significant federal developments accelerated the community mental health movement and the process of deinstitutionalization. First, passage of the Community Mental Health Act of 1963 was part of the general expansion of the federal government's role in social welfare programs. It provided for funding a national network of community mental health centers to deliver inpatient and outpatient services, transitional care, emergency care and consultation/education programs. The act projected creation of 2,000 community mental health centers. No more than a third of this goal was ever achieved due in part to inadequate funding and naive expectations. The community mental health center legislation provided incentives for the development of community programs, but it was permeated with notions of the efficacy of community care to cure mental illness.[4] This early view of the institution as a curative environment was succeeded by an assumption that community care was curative.

Second, at the same time the federal government was fostering community mental health centers, it was enacting sweeping changes in funding for social welfare programs. Under the "Aid to the Disabled Program," now called Social Security Income (SSI), the permanently disabled became eligible for federal financial support in the community.[2] SSI supplements enabled states to place patients, whose primary support was 50 percent federally funded, in the community where costs were much lower. Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act in the mid-1960s provided aid for medical care for the aged and poor, and created alternative means of supporting the medical needs of the mentally ill in the community. However, Medicaid did not pay for adults 22 to 64 residing in an "IMD" (Institution for Mental Disease), which had a double impact on state institutions:

- It barred federal support for *most* patients in state mental hospitals, thereby limiting a possible source of funds that could improve hospital care, and continued to place the financial burden for long-term care for the adult mentally ill on the states;
- It created a fiscal incentive for states to move patients 22 to 64 to other forms of care eligible for Medicaid, such as nursing homes, community settings with outpatient services, and general hospitals.[2]

Without these federal entitlement programs, deinstitutionalization would not have happened as quickly, nor in the same magnitude.

B. Deinstitutionalization

Deinstitutionalization, occurring largely between 1955 and 1978, had three ambitious goals:

1. To prevent inappropriate mental hospital admissions through provision of community alternatives for treatment;
2. To release to the community all institutional patients who had been adequately prepared for release; and
3. To establish and maintain community support systems for persons receiving mental health services in the community.[5]

In addition to the development of psychotropic medications, the philosophy that community treatment is better, and available federal funding, other factors also contributed to deinstitutionalization. In the social reform era of the 1960s, a more activist judiciary began listening sympathetically to patient rights advocates who challenged the manner in which states dealt with mentally disabled citizens. A number of major legal principles evolved that accelerated the deinstitutionalization process including:

1. Establishment of "dangerousness" as a criterion for involuntary commitment (*Donaldson v. O'Connor,* 1972);
2. Right to treatment in the least restrictive environment for those accepted into treatment (*Lake v. Cameron,* 1966); and
3. Right to fair and reasonable conditions in institutions, which contributed to rising institutional costs and provided yet another incentive to states to release patients to the community. Landmark cases include those relating to the right to treatment (*Wyatt v. Stickney,* 1971) and the right to freedom from harm (*New York State Association of Retarded Children v. Rockefeller-Willowbrook,* 1973).[6]

Several states, including New York, had begun discharging their inpatients prior to these legal decisions. New York's inpatient population fell from the 1955 high of 93,000 to 76,000 in 1968—an 18 percent reduction. During 1964-68, legislative and policy changes further affecting the census of mental hospitals included:

- *Reform of the admission laws* in 1965 abolished court certification and provided for admission based on medical judgment; provided for court hearings on request and at stated intervals; required notification of parents and next-of-kin of patient rights; and estab-

lished the Mental Health Information Service to protect and advocate for the rights of patients;

- *Administrative reorganization* of state hospitals based on geographic areas with the goal of linking them to local service systems; and,
- *Promulgation of a new admission policy in 1968* where prospective patients were rejected for admission "if care and treatment would more appropriately be given in another facility. Patients should not be admitted when their problems are primarily social, medical or financial or for the convenience of some other facility."[1] The intent was to direct inpatient facilities to serve only patients who required mental health care.

The new admissions policy signaled the full-scale deinstitutionalization of New York State mental hospitals, which continued until 1978. The inpatient census was further reduced from 76,000 in 1968 to 35,000 in 1975—a 54 percent decline.[2] This refocused function for state hospitals occurred without full consideration of the multiple needs of institutionalized patients, and assumed that communities were adequately prepared to care for seriously mentally disabled persons previously institutionalized. In the early years, it was thought that most patients would immediately be welcomed into and respond positively to community life. However, community services for the chronically mentally ill were not adequately developed, guidelines for discharge were unclear, and state/local coordination was lacking.

In addition, many mentally ill persons who were totally unprepared for community living were released into various kinds of low-income housing including single room occupancy (SRO) hotels and rooming houses. Although often in substandard physical condition, such housing afforded some semblance of a support network, however inadequate.

During the 1970s and early 1980s, many former patients became homeless, as the substandard dwellings that had formerly provided them with asylum fell prey to gentrification pressures and were converted to higher income co-ops. A local property tax abatement and exemption program in New York City and illegal and grossly inhumane eviction practices contributed to the wholesale dumping of previously discharged patients. The Reagan Administration's discontinuance of low-income housing programs and the city's late response to pressures for illegal displacement hastened the development of the homeless crisis. Neither the state nor federal governments provided alternate housing. Many former mental patients were forced to seek housing on their own, and some were placed in nursing homes, even though nursing homes are reluctant to accept mentally ill persons.[7]

More recently, federal denials of SSI and SSD disability determination reviews have reduced the number of eligible recipients. Dramatic reductions in federal disability benefit rolls have forced many mentally disabled individuals either to attempt to substitute home relief income assistance at lower rates than the SSI they had been living on, or to fall completely out of touch with relief and service systems and join the ranks of the homeless.[6]

Not until the mid and late 1970s did mental health leadership demonstrate recognition that comprehensive and coordinated supports were required to maintain persons with long-term disabilities in community settings. In New York, funding programs such as chapter 620, (providing state aid for services to individuals who have a length of stay of five years or longer in a state psychiatric center), community support services (providing 100 percent state aid for services to previously hospitalized seriously mentally ill individuals), and community residences (providing 50 percent of total operating costs for community residences) were enacted during this period.

C. Influences on the Treatment of the Mentally Ill

The mental health system must be viewed in the context of broader social and economic forces that may unexpectedly change and affect the course of service delivery. As noted earlier, emphasis on institutional reform, civil rights and community care was reflected in deinstitutionalization and establishment of community mental health centers. More recently, public criticism of deinstitutionalization has led to legislation and policy that give more attention to public protection and greater scrutiny on placement of psychiatric patients in community settings. This trend is evident in citizen concern over location of community residences in their neighborhoods.

Economic forces profoundly affect mental health treatment. Poor economic conditions and high unemployment create additional stress for persons at risk of mental illness, and place significant burdens on their families. Suicide, psychiatric inpatient admissions and the demand for outpatient services increase proportionately to rising unemployment rates and economic recession.

Also, the availability of funding affects the system's ability to provide quality care and meet emerging needs. The recent economic recession resulted in federal policy that curtailed welfare expenditures. Not only has direct financial support in the Alcohol, Drug Abuse and Mental Health Block Grant appropriations been sharply cut, but in its SSI/SSD and housing policy, the Reagan Administration has withdrawn fiscal support from the states and localities.

The federal government has placed the burden of care for the long-term mentally ill on the states. The pressure on the states has been enormous. The state mental health care system, with large aging physical plants requiring large capital outlays and with demands for improved staffing to meet quality care and accreditation standards, now costs New York approximately $1.2 billion annually.[8]

The nation's social and economic policy is clear. Mental health care is the responsibility of state and local governments. The state is a prime payor and the single locus for balancing shifting economic realities and social and political pressures. State, local governments and voluntary providers are all responsible agents for the local management and direct delivery of care. Their integrated effort is essential to future success.

As the characteristics of patients and outside influences have changed, so too have the roles of the state and local mental health systems. The success of new treatment modalities has demonstrated that the seriously mentally ill may require supportive services for life. The challenge now is to move the institution's positive functions—shelter, food, clothing, work experiences and good medical care—to the community in an integrated, comprehensive way.

A comprehensive, integrated system must guarantee that:

1. The patient is the focal point; therefore, the organization of services, the funding flows and the system of accountability must all revolve around the individual;
2. A broad range of care is available on an intermittent and long-term basis for life, if necessary;
3. Care for a chronically mentally ill person is provided that includes: clinical treatment in partnership with family and friends of the patient; case management services; an appropriate residence; and provision for rehabilitative and supportive work activities;
4. Provision of appropriate residence and supportive work activities is advocated and in many cases provided directly by the mental health system;
5. Direct mental health care is part of an integrated range of health, social service, housing, and legal services necessary to sustain the mentally disabled;
6. The system integrates state and local government and voluntary, institutional and non-institutional providers;
7. Organization and funding of services, while structured, are flexible to reflect the changing manner in which needs of the mentally ill are manifested, and the fact that social, political, and economic influences themselves constantly change and influence the mental health care system.

3 Key Problems and Issues

in New York State's Public Mental Health System

IN ITS EXTENSIVE STUDY of New York State's mental health system, the Select Commission identified several major problems with serious policy implications—problems that have been repeatedly singled out in previous studies. Mindful of the historic failure to resolve these issues, the Select Commission decided to pursue a realistic course, one that would set in motion a process of improvement which could begin to be implemented during the present administration.

Since the passage of its Community Mental Health Services Act in 1954 (the first in the nation), the state has witnessed a steady movement toward care in the community. The development of new psychotropic medications, judicial decisions establishing the right to treatment in the least restrictive setting and fiscal incentives to reduce the census of state psychiatric centers have led to a dramatically expanded role for local government and the voluntary sector in the provision, funding and management of mental health care. What was essentially a state-operated mental health system, financed almost entirely by state funds, now involves approximately 2,500 programs, under diverse auspices, driven by a complex array of state, federal and local funding streams. These include 891 licensed outpatient units, 126 licensed inpatient units, 210 licensed community residences, 846 licensed family care homes, and 419 community-based non-residential programs, such as psycho-social clubs, which do not require licensure. Of the 1,646 non-family care programs, approximately 70 percent are operated under local and private auspices while 30 percent are operated directly by the Office of Mental Health.

It is now clear that mass deinstitutionalization is virtually over—no longer will tens of thousands of patients be discharged from state psychiatric centers. Data nationally indicate that the 20-year trend of census decline in psychiatric hospitals tapered off markedly during the past five years. While the average yearly decline in New York State had been as high as 14 percent during the late 1960s and 1970s, this decline is currently at two percent, with most of the reduction being accounted for by the deaths of elderly patients.[9] The overall census* in state psychiatric centers has leveled somewhat and the development of an integrated service system on the community level should become the pre-eminent policy concern of the state.

The result of 30 years of incremental change—in services, financing and auspices—has left New York's public mental health system confused and fragmented. A commonly held perception is that a coordinated public mental health system is nonexistent in this state. Where public mental health services are provided efficiently and effectively, they have been accomplished in spite of the present structure, not because of it.

Perhaps what is most remarkable is how well New York's public mental health system does serve the mentally ill. The public and voluntary systems treat an estimated 500,000 or 2.8 percent of the state's population annually in spite of the underlying structural problems. Many individual programs under state, as well as local and voluntary auspices, continue to provide excellent services; some are nationally acclaimed models.

The following discussion focuses on who is served and where services are received. There is a fairly broad consensus of opinion on the barriers to effective service delivery, financing and management. These problems and issues are discussed below in the context of their impact on the public mental health service delivery system in New York.

A. Understanding the Public Mentally Ill Population

Two therapy aides watch anxiously as Roland, a strong, aging-out patient, becomes irritated and ready to "blow" for the third time this month. Roland has been discharged before and each time comes back more hostile. Roland knows all the "ropes." He knows his rights—including leaving and not taking his medication. He has access to drugs when he's "out." The therapy aides feel futility when they think about helping or managing Roland and they know when Roland leaves, he will not have the community services and programs which might prevent his readmission next time. He is one of many for whom the system offers only a revolving door.

In 1978, the President's Commission on Mental Health estimated that 15 percent of the population may need mental health services at any one time (approximately

*Although the total census has leveled off in recent years, particular demographic groups (eg., young chronics, the elderly) could exert increased pressure on the need for more beds at times.

2.5 million people in New York State).[10] The National Institute of Mental Health, based on its own studies, agrees with this 15 percent annual prevalence rate. However, a relatively small percentage of that population seeks treatment and an even smaller percentage is actually treated by the public mental health system, although many are treated by private practicing psychiatrists, psychologists, social workers, etc., and in the general health sector.

Currently across the nation, 1.7 to 2.4 million persons are considered chronically mentally ill. Included in this population are 150,000 persons who have received inpatient care for over a year; 750,000 who live in nursing homes; and 800,000 to 1.5 million who live at home, in community residential programs or independently, or are homeless.

National trends indicate that mental health services are in greater demand than ever before. With inpatient admissions stabilizing, the number of patients seen in outpatient settings throughout the country doubled between 1970 and 1980. The characteristics of patients seeking mental health services have also changed:

- The young adult population between 18 and 45 (the age range in which the onset of many chronic mental disorders, including schizophrenia, occurs) comprises a higher proportion of admissions than any other age group.[11] In New York State, this younger population represents over 50 percent of inpatient census.
- Patients with schizophrenia comprised nearly half of all resident patients in both 1969 and 1979, but the patients diagnosed with alcohol and drug disorders comprised a higher proportion of total admissions in 1979.[12]
- Patients are sicker and more difficult to treat with traditional modalities, necessitating development of new innovative approaches:[13]
  - —Major advances have been made in the research and development of new psychotropic medications which stabilize mood and behavior and control symptoms. National statistics indicate that 73 percent of all mental patients were treated with drugs in 1980 as compared with 56 percent in 1975.[12]
  - —Treatment approaches based on the psycho-social model have demonstrated considerable success. Based on the idea that functional disabilities can be reduced through planned environmental intervention, this approach provides patients with the opportunity to participate in social and vocational activities. The Fountain House program in New York City, which has an international reputation for helping patients with long-term disorders to live productively in the community, stresses that the mentally ill require a sense of belonging, participation and responsibility, and an opportunity to work.[9]
  - —Other treatment approaches include the balanced service system, designed to strengthen individual functioning through reintegration of the individual into a normal lifestyle, and the community support system, (CSS), which designates a core service agency in a locality that is responsible for identifying and securing needed treatment, rehabilitation and support services for eligible persons. The CSS program focuses on the chronically mentally ill person who does not require long-term institutional treatment. Case management, a vital part of both of these approaches, assures access to services and promotes continuity of care and accountability.[7]
- Residential programs have been a major focus for children and youth. However, statistics indicate that children with psychiatric problems are more frequently served while living at home, or by other state service agencies, and are more likely to attend public school programs.[14] Comprehensive community services are not widely available for them. The failure of the mental health system to be mobile and accessible is a major impediment to quality care. The importance of reaching this population is further underscored by statistical findings which reveal that 50 to 80 percent of mentally ill children retain their disability as adults.[7]
- Over the past few years, increasing attention has been paid to those mentally disabled youth who have been served by the child caring systems but who are no longer eligible for child care because they have "aged out" and must now be served by the adult care systems. In New York, most seriously disabled children are served by the educational and/or social service systems, in which special education or child care eligibility expires at 21. For those aging-out youth who are mentally ill and require ongoing and sometimes life-long care, responsibility must be shifted from educational and social service programs to the mental health system. Over the past three years, several laws have been enacted which establish transitional planning and referral mechanisms for the aging-out population.
- According to national population projections, the percentage of elderly in the total population is increasing. Correspondingly, the number of mentally ill elderly is also on the rise. The rate of individuals over 65 being served by the mental health system is growing. Almost 1,000 individuals per 100,000 elderly persons within the general population are served as compared to an average of 720 per 100,000 for all age groups. New York statistics show that in 1982, for the first time since 1968, there was an increase in admissions to state inpatient psychiatric centers among individuals older than 65.[9]
- Mentally ill homeless persons are a major and growing population that requires the attention of the mental health system. While new supportive housing, outreach and mobile treatment services have been developed in the past few years, they are insufficient in number and require further development. New and innovative treatment models must be designed, implemented and evaluated if the mental health system is to serve this population.[15]

The Office of Mental Health conducted surveys of patient characteristics in 1981 and 1982. These one-week

point prevalence surveys covered the entire New York State public mental health system and obtained data from 99 percent of the provider network. Data derived from these surveys have been very helpful in describing patterns of mental health service utilization in New York.

During a given year, approximately 500,000 people are provided mental health services by New York's public mental health system. The services provided range from hospital inpatient days to sheltered workshop visits. Table A summarizes the scope of mental health services during 1982 and the relative utilization of state and local services.

TABLE A
Distribution of Services by State and Local Providers New York State – 1982

Service		State	Local
Residential	**Days**	%	%
Inpatient	10,200,000	82.8	17.2
Family Care	900,000	100.0	
Community Residence[1]	700,000	10.1	89.9
Other[2]	100,000	79.2	20.8
TOTAL	11,900,000	78.9	21.1
Non-Residential	**Visits**	%	%
Clinic Treatment[3]	4,900,000	22.3	77.7
Day Treatment	900,000	30.9	69.1
Continuing Treatment[4]	1,500,000	50.7	49.3
Certified Work Activity	600,000	33.7	66.3
Other[5]	800,000	38.1	61.9
TOTAL	8,700,000	30.9	69.1

1 includes crisis residence
2 includes emergency holding beds, forensic dormitory and forensic observation
3 includes emergency unit clinic
4 includes on-site rehabilitation and day training
5 includes classroom education, psychosocial club and special procedures (pre-admission screening and case management) which are not part of a specific program

Source: New York State Office of Mental Health, 1982

A number of conclusions can be reached from this information:

- Inpatient days are the predominant modality of residential service.
- State-operated inpatient programs are the major provider of inpatient days (82.8 percent), although local general hospitals provide the majority of acute (less than 90 days) psychiatric inpatient care.
- Clinic treatment is the largest non-residential (outpatient) program provided in New York State (56.3 percent of all visits)—three times the size of the next largest category.
- Local agencies are the major non-residential service providers (69.1 percent).
- Local agencies provide 89.9 percent of all community residence days, while virtually all state community residence days are in family care.

The following selected characteristics of New York State's public mental health system drawn from Office of Mental Health survey data, highlight some of its features.[16]

- Adults are the predominant population receiving both residential (58.3 percent) and non-residential services (71.9 percent).
- The majority of people are served by local non-residential services, approximately 57 percent.
- Children and youth (0-18) are primarily served in non-residential (outpatient) services, while the elderly (65 and over) are primarily served in residential services. Adults (18-64) predominate in both residential and non-residential services, accounting for 58.3 percent of residential and 71.9 percent of non-residential services.
- Children had the lowest rate of residential days per 100,000 population, followed by adults, with the elderly having the highest rate.
- For non-residential visits, children had the lowest rate per 100,000 population followed by the elderly and the adult population.
- Of all individuals seen, 72.8 percent were White, 17.6 percent were Black, 8.6 percent were Hispanic and 0.9 percent were Asian, native American or other ethnicity.
- Blacks were more likely to receive services than other groups.
- Over 54 percent of those seen had major psychiatric disorders—affective disorders, schizophrenia or other psychoses.
- Frequently referred to as the mentally disabled or mentally handicapped, a large number (24.9 percent) of those served in the mental health system are multiply disabled or multiply handicapped. The multiply handicapped are individuals who have two or more disabling conditions that lead to functional or life skills impairment (e.g., mental illness, mental retardation or other developmental disability, alcohol abuse, substance abuse or physical handicap). A particular problem related to serving the multiply handicapped is the determination of the primary handicapping condition, and, ultimately, which agency or system should assume primary responsibility for services.
- The amount and types of service per 100,000 general population vary considerably across regions of the state. For example, New York City is high in inpatient days and visits per 100,000, but relatively low in community residence and family care days. The upstate regions are much higher than New York City and Long Island in family care days. The Hudson River region exceeded other regions in community days per 100,000. New York City was highest in clinical

treatment; Hudson River was highest in day and continuing treatment and crisis services; Long Island was highest in day training, sheltered work and classroom education; and Central New York was highest in case management.

TABLE B
Major Age Groups of Population Receiving Mental Health Services in New York State – 1982

	Children & Youth	Adult	Elderly
Residential Days	%	%	%
Inpatient	3.8	56.7	39.5
Family Care	0.9	49.1	50.1
Community Residence[1]	4.0	86.6	9.4
Other[2]	4.0	90.8	5.2
TOTAL	3.6	58.3	38.1
Non-Residential Visits			
Clinic Treatment[3]	21.0	73.0	6.1
Day Treatment	30.7	61.3	8.0
Continuing Treatment[4]	2.6	74.1	23.3
Certified Work Activity	0.8	90.3	8.9
Other[5]	23.5	64.8	11.7
TOTAL	17.8	71.9	10.4

1 includes crisis residence
2 includes emergency holding beds, forensic dormitory and forensic observation
3 includes emergency unit clinics
4 includes on-site rehabilitation and day training
5 includes classroom education, psychosocial club and special procedures (pre-admission screening and case management) which are not part of a specific program.

Source: New York State Office of Mental Health, 1984

The Office of Mental Health patient characteristic survey also helped the Select Commission to describe the following three categories of mentally ill persons in terms of the frequency with which they came in contact with the provider network.

1. Long-Term Care Population

The first group is composed of a large number of persons who have continuously lived in state psychiatric centers or in family care residences for an extended period of time. In 1982, 59.4 percent or more than 13,400 patients had been in residence more than five years. Among state psychiatric centers, this varies from 40 to 70 percent of the total census. Some of these long stay patients no longer require intensive psychiatric care, although they do require asylum care, and could be maintained in community residential facilities with appropriate support services. Until community alternatives are developed, most of these persons will remain in one of the 33 state psychiatric facilities, of which 23 are for adults and six are for children. In addition, there are two forensic hospitals and two research institutes.

State psychiatric centers provide a wide range of services, including the primary provision of intermediate and long-term patient care, as well as the provision of acute inpatient care. Their principal role is to provide specialized psychiatric care to aggressive, violent adults and children, multi-disabled individuals, sentenced and non-sentenced forensic patients, and the aged, including the very infirm and frail elderly. Lastly, they provide a substantial amount of community-based care through shared staffing and other community residential programs.

State facilities have become multi-purpose service campuses housing programs to meet a wide spectrum of community needs beyond those of the mentally ill. There are over 100 different public and voluntary agencies utilizing the state psychiatric center campuses. Major programs include six centers for the mentally retarded, 13 alcoholism treatment programs, two major shelters for the homeless, four prisons and a major college. Presently over 90 percent of all buildings that are in usable condition are occupied by the Office of Mental Health and other providers. New York State facilities provide mental health services to people throughout the state and in some communities represent the only psychiatric resource.

2. The System Dependent Population

In addition to those patients requiring virtually lifetime care at a state psychiatric center, there are others who, though severely and chronically mentally ill, are capable of functioning in the community. These individuals require a highly structured level of support, preferably coordinated by a single caregiver. This is a very difficult population group to quantify. Eighty-seven percent of inpatient days provided by the local mental health inpatient service sector and 42 percent of outpatient visits in the state and local outpatient service sectors are used to render care to mentally ill persons with functional psychoses. [17]

The issue of where people should receive treatment is particularly important for this group of persons who will have frequent contact with the mental health system. There is reason to believe that there is excessive dependence on hospital treatment. In a 1982 article published in *American Psychologist,* Kiesler reviewed 10 studies in which serious psychiatric patients were randomly assigned to either inpatient care or some alternative mode of outpatient care (noninstitutionalization). In no case were the outcomes of hospitalization more positive than alternative treatment. Typically, the alternative care was more effective, as measured by such outcome variables as psychiatric evaluation, probability of subsequent employment, independent living arrangements, and staying in school. It was also decidedly less expensive. The studies provide clear evidence of the self-perpetuation of hospitalization, as hospitalized patients were more likely to be readmitted to the hospital.[18]

3. Periodically Served Population

A third population group is composed of those individuals who use the public mental health system episodically. The vast majority of these persons do not

require frequent or continuous contact with the mental health system. Episodic and new users of services often first enter the general health care sector for mental health services; e.g., private physician or short-stay hospital emergency room. The latter is often the entry point as a result of Section 9.39 of the Mental Hygiene Law mandating emergency admission if the patient is felt to have mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others. In fact, the National Institute of Mental Health estimates that a majority of those receiving mental health services receive them in the general health care sector. Many individuals, especially children, may receive services in the educational and social services sectors, as well. In addition, about 20 percent of persons receiving mental health care use the services of private psychiatrists, private psychologists and private mental hospitals.

B. Impediments To Quality Mental Health Services

The Honorable Benjamin J. faces a dilemma in dealing with 17-year-old Johnny S., who came before him on the charge of car theft. Johnny has a history of fighting, truancy and being uncooperative. His behavior stems from long-standing problems at home. Johnny's father is an alcoholic, his mother abused, and neither can deal with Johnny's needs. The appropriate response to this situation would be immediate intervention services, temporary removal from the home, and family counseling. However, these options are not available in Johnny's community. The judge must choose between jail and a distant psychiatric center. So Johnny will enter adulthood, labeled either as mentally ill or criminal because of a lack of a continuum of mental health and supportive services in his community.

New York's public mental health system is as complex as any state system in the nation. Over 2,500 providers are licensed, funded or regulated by the Office of Mental Health. They serve over half a million people each year. Perhaps the key descriptive term is diversity—in availability, in who is served, in program design, in duration of service, and in intensity.

This diversity is both the system's greatest strength and its most serious weakness. Innovative and creative providers have developed programs that have become models for the country—the 1983 Gold Achievement Awards of the American Psychiatric Association were given to South Beach Psychiatric Center on Staten Island, the Compeer Program of Rochester and the Rockland County Unified Services Program. On the other hand, many programs are of uncertain efficacy, and the system's very complexity has made the assurance of appropriate care and treatment uncertain.

In the Select Commission's review of service system issues, four principal problems emerged:

- Lack of a comprehensive continuum of services in many areas of the state;
- Problems in access to care;
- Serious barriers to continuity of care; and,
- Lack of standards to assure the quality and appropriateness of care.

1. Need for additional services and better distribution—There are serious problems in ensuring a full range of services from intensive acute inpatient care to supportive residential and outpatient services. The system tends to respond to critical episodic needs without adequate follow-up and preventive services. One result of this response is the "revolving door" phenomenon.

Patients who cannot be discharged due to a lack of alternative services or housing in the community fill costly general hospital and psychiatric center beds. Underemphasis on preventive programs and family support services exacerbates the need for a more intensive level of services. More specifically, deficiencies in special needs housing* and effective community-based crisis care programs are critical failings.

2. Access to services—Children, minorities and the elderly are among those population groups that are most inadequately served. Programs are not sufficiently relevant or staffed to respond to the ethnic and cultural mix of the community. Those with multiple disabilities, particularly drug or alcohol involvement, find too few programs available, while the medically indigent face financial barriers. Often only the most severely ill are admitted to treatment because the service system is overloaded. Early intervention, treatment and stabilization are delayed and often later increase the degree of disability and costs. The emergence of a growing young chronically mentally ill population (18-45) is posing particularly difficult questions regarding treatment and outreach. There are few incentives, fiscal or other, to stimulate providers to develop comprehensive rather than episodic response programs.

3. Need for structured care delivery—With the multiple levels of care available, a patient could move from a hospital to a day treatment program, live in a community residence, receive medication maintenance from a number of providers, and later move to a domiciliary care setting and be served by a rehabilitation program. This complex care plan should be a common occurrence for the seriously ill, yet movement among care settings is often thwarted by differing provider standards and admission criteria.

The public mental health system has problems ensuring that appropriate care exists and linking it to other human services. The vast numbers and diversity of providers within the system have made matching a client's needs to appropriate services a complex, difficult and often impossible task. Each provider, beyond fulfilling state minimum standards, may define very different pro-

*Supportive and supervised community residences, crisis residences, domiciliary care facilities, residential care centers for adults, residential treatment facilities and other congregate care housing.

gram design and admission criteria, which in turn can create serious barriers to appropriate care. Too often there is no one to refer, monitor or advocate for a patient with multiple needs, such as health care, housing, employment and income support. The entire range of human service agencies may be involved. The lack of coordination and effective access to these human services is a profound problem with few mechanisms extant to assure coordinated care. This is an especially severe problem for children and the young chronically mentally ill.

4. Is success measured?—Great strides have been made in the development of program standards which define staffing requirements, cost limitations and treatment protocols. There is a critical lack of population-based planning standards and outcome standards which measure efficacy. The tremendous variations in mental health resources across the state, and the availability and use of services, reflect a lack of need methodologies which should determine the quantity and type of service necessary for a given geographic area. Both the literature and anecdotal evidence suggest that there are distinct differences in program effectiveness; some reduce hospital care or return patients to sheltered or full employment better than others. Further evaluation of the quality of services should focus on these outcomes so the system can foster what works and change what does not. Finally, it is essential that workable service models be well defined and employed.

C. The Dilemma Of Mental Health Financing

Barry C., a young adult schizophrenic, lives with his parents. He attends the local mental health clinic, and medication controls his tendency to violent outbursts. Barry lacks social and vocational skills, but the local government has not planned or budgeted for services beyond the core Medicaid-eligible services and CSS program, primarily provided through shared staff. Barry would benefit from a vocational training/placement program and a social club environment. Unfortunately, he is not CSS eligible and will probably become a regular at the clinic. Without skill development, as his parents become older, Barry will become increasingly dependent on the mental health system. He is one of a large population for which community services are not planned or funded.

Mental health program development efforts are heavily influenced by available funding mechanisms. Too often, programs are developed in response to funding streams rather than to patients' defined needs. Recent funding mechanisms have tended to be categorical in nature, that is, they have particular client eligibility criteria. As a result, persons not qualifying may go unserved. In addition, some funding may be available only if services are provided by a particular type of provider. For example, Medicaid brought hundreds of millions of federal dollars into New York and increased the availability of mental health services. Unfortunately, the program also led to over-reliance on expensive, often inappropriate, inpatient services.

Providers of mental health services must deal with several different sources of public funding, all with separate accountability and incentives. This complexity confounds both providers and clients. The administrative burden of dealing with detailed, perhaps conflicting, rules, regulations and procedures often obscures the basic responsibility of providing effective care. A patient's clinical need for appropriate services and not financing considerations should dictate entrance into the mental health system.

Table C describes public funding sources available to finance mental health services in New York. The table is not exhaustive, although it does provide a vivid illustration of the multiplicity of funding sources for mental health care.

"A review of the funding sources reveals that their administration is dispersed among several different federal, state and local government agencies. Mental health funding also is subject to diverse formulas, methods and eligibility requirements for reimbursing costs. Some funding processes are categorical (Medicaid), some purchase units of services (Community Support Services), some are deficit financing (State Aid), some require matching local funds (State Aid), and some require no local match (Chapter 620). Mental health financing is currently made up of a diverse and complex maze of funding sources with accountability widely dispersed among many government agencies.

"The range of county per capita local mental health expenditures varies as much as the methods of distributing funds. Analysis of 1981 preliminary county budgets indicates:

- Gross per capita local expenditures ranged from $2.04 to $130.00.
- Local government funds per capita ranged from 49¢ to $15.70.
- State aid funding to counties on a per capita basis ranged from 92¢ to $27.93.[6]

"In summary, the diverse methods of financing have led to a complex system that thwarts accountability and, in addition, appears to have affected the distribution of mental health funds across counties."[8]

Medicaid and state government funding account for more than two-thirds of New York's aggregate funding for mental health services. Private health insurance, foundation support and philanthropic contributions are less than 10 percent. In the future, if the federally mandated D.R.G. reimbursement system is implemented in New York State, additional financial pressure would be placed on short-stay acute hospitals.

Except for Unified Services, most funding mechanisms were developed to meet a specific need, solve a crisis, or provide services to a particular group, rather than to help build an effective mental health network. Although recent funding sources and mechanisms have

TABLE C
Sources of Public Mental Health Services Financing in New York State – 1984

Source	Description
Federal	
Medicare	Limited inpatient and outpatient coverage for the treatment of mental illness for persons 65 and over and some disabled persons (introduced in 1965).
Medicaid	50 percent federal reimbursement for a wide range of inpatient and outpatient services for those who meet income eligibility standards (introduced in 1965).
Supplemental Security Income (SSI)	Basic monthly income to the aged, blind or disabled based on income eligibility standards. State has an option to supplement these federal dollar amounts (introduced in 1974).
Community Mental Health Centers Act	Federal funds for construction and staffing of multi-purpose centers (introduced 1963-65).
Alcohol, Drug Abuse and Mental Health Block Grant (ADM)	100 percent of the net operating expenses incurred by contractors in support of the Community Mental Health program as defined under the federal omnibus legislation.
STATE/LOCAL	
State Purposes	100 percent New York State dollars to support state mental hospitals, hospital-based outpatient services and the family care program.
State Aid to Localities	Local governments are granted state aid for approved net operating costs, pursuant to an approved local service plan, at the rate of 50 percent of the amount incurred during the local fiscal year by local governments and voluntary agencies under a contract (introduced 1954).
Unified Services Plan Financing	The net deficit incurred by a county pursuant to an approved unified services plan is funded by the state (introduced 1973).
Chapter 620 of the Mental Hygiene Law	Local governments or voluntary agencies having a contract to provide services to persons who were patients in a state facility for a period of five or more years following January 1, 1969, are granted state aid at the rate of 100 percent of approved net operating expenses (introduced 1974).
Community Support Services	A mechanism for building comprehensive and integrated mental health services for a chronically mentally ill population, the program is intended to forge a partnership among service agencies whose common goal is meeting the community living needs of the target clientele. Funding is provided at the rate of 100 percent of net costs (introduced 1977).
Direct Sheltered Workshop	Voluntary not-for-profit agencies which receive income through the operation of a sheltered workshop or industrial contract may have that income matched dollar for dollar through direct contract.
Program Development Grants	Local governmental units and voluntary nonprofit agencies may receive state funding in an amount not to exceed 80 percent of the development costs for community residential facilities, including but not limited to group apartments and other transitional living arrangements for the mentally disabled.
Demonstration Grants	Local governments and voluntary provider agencies are granted state aid of 100 percent of the net operating costs pursuant to contract with such local governments and voluntary agencies for approved demonstration projects.
Subcontract Funding – Local Assistance, Chapter 620 Community Support Services, ADM Block Grant	Agencies which subcontract with a core service agency of a Community Mental Health Center receive 100 percent of their local assistance funding through the core service agency of the CMHC which in turn receives its funding from the state.
Community Residence Funds	State aid is available to local governments and voluntary agencies, not to exceed 50 percent, for acquisition or construction of community residences for the mentally disabled and for operating costs.
Community Residence Rental Costs	Funding is provided for all rental costs incurred for community residence programs at 100 percent of net cost.
Family Care Adult and Children	State aid is provided to cover 100 percent of net cost.
Group Homes	A funding mechanism used by the Office of Mental Health (OMH) to supplement the State Department of Social Services rate in the amount of $5,000 per bed per year. OMH will fund 100 percent of the net as long as the net does not exceed the cost per bed rate.
OTHER	
State Facility Fee for Service Contracts	The Commissioner (OMH) establishes fee schedules annually for inpatient and noninpatient services.

Source: New York State Office of Mental Health, 1984.

fostered development of new community-based programs, they have also created problems. For example, each funding mechanism established its own eligibility criteria, reimbursement levels and matching requirements; specified the types of programs and services that were reimbursable; and required the development of discrete information and reporting procedures. Such mechanisms led to program development based on funding criteria and availability rather than on patient needs. In addition, they shifted costs from local government to the state and from the state to the federal government and set eligibility criteria which created barriers to many functionally disabled persons receiving services. They also offered no fiscal incentives to reward efficient performance or to provide treatment in the least restrictive therapeutic settings.[19]

Funds directed to provider agencies sometimes fail to provide the most needed services or to reach patients in greatest need because the agencies must respond to multiple economic incentives. In many cases, the design of eligibility criteria and covered services does not encourage the most appropriate or cost-effective care. For example, Medicaid provides complete coverage for inpatient and nursing home costs, but only partial coverage for outpatient costs. This coverage does not extend to several of the most important outpatient services required by the chronically mentally ill.

Reliance on the Medicaid program as a principal source of funding has resulted in cost shifting among levels of government and in a highly medicalized mental health network. The Medicaid formula in New York is based on 50-25-25 percent federal/state/local cost sharing. Although federal regulations prohibit Medicaid reimbursement for persons 22 to 64 in state mental hospitals, it is available in general hospitals. Since the state pays 100 percent of the costs of care in state mental hospitals for this age group, there is a fiscal incentive for the state to promote inpatient psychiatric care in general hospitals. Conversely, local governments have a fiscal incentive to promote inpatient care in state mental hospitals since the state pays 100 percent of such costs. Consequently, state and local mental health authorities may operate at cross purposes, with financial considerations taking precedence over patient needs. The Medicaid program's incentives for use of general hospitals as a primary site of treatment conflict with the basic tenets of sound community mental health care which emphasize alternatives to hospitalization.

D. Management Barriers— Who's in Charge?

Beth is 42 years old and has been in and out of state mental hospitals for 25 years. Between hospitalizations, she has lived with a grandmother, in boarding homes, in welfare hotels and on the streets. Her current address, according to psychiatric center records, is a vacant lot. No one seems to know where or how she lives. Despite miles of computer tape and voluminous records from at least five health and human service agencies, Beth is lost to the system.

"When state mental hospitals constituted the primary treatment site for the mentally ill, the provision of mental health care and treatment was a simple process—patients entered the system, were treated and discharged all at one site. Since the state was the major provider, state responsibility, especially for the severely and chronically mentally ill, was a reasonable and generally accepted concept. As policies changed and new providers emerged, an explosive growth of community-based programs occurred. Today, inpatient, outpatient and residential services in New York State are rendered in hospital-based and freestanding facilities by federal, state, local, voluntary and proprietary providers. State hospitals are now only one component in an expanded network."[20] Yet these hospitals continue to receive the major share of state funds contributed to the total system.

The size and complexity of the public mental health system, and the need to work toward a truly integrated system, require that well-defined roles and responsibilities be assigned to the most appropriate providers and government agencies. On a management level, it is necessary to ensure that policies are developed, articulated and implemented uniformly and that the system progresses toward its goals. At present, this is not the case. On a services level, mentally ill persons often do not enter the system in a logical manner, fail to receive needed services, and leave the system with no appropriate follow-up plan of care.

In New York State, management of the public mental health system is largely uncoordinated, often crisis oriented and without consistent direction. The multiple levels of government involved, and the independence of many provider systems, have diffused and confused roles and responsibilities, making it difficult to assure that mental health services are coordinated.

In the 30 years since passage of the Community Mental Health Services Act, no clear delineation of management and service delivery roles and responsibilities has occurred. There is no formal process to govern a patient's entry into, movement through and exit from the system. The system is the result not of rational design but of chance availability of services and the willingness and ability of providers to serve.

The state's public mental health system lacks the clarity and direction necessary to function optimally in a purposeful and structured manner. What has developed, unintentionally, is a mental health network operated primarily by the exigencies facing providers, rather than exclusively by the needs of the persons served. Indeed, it is a system motivated by outdated organizational functions, practices and behaviors, and unable to redirect its mission and goals to complete development of a community-based mental health system.

During these three decades, voluntary and local government sectors have indeed assumed major roles in the delivery and management of mental health services—roles that differ dramatically and are spread unevenly across the state. But the development of effective mechanisms to link the three major sectors—state government, local government and voluntary providers—has not occurred.[21]

The 1981 Tripwire Agreement in New York City illustrates the absence of coordinated mechanisms and effective communications. It reflects an accord between the state and city that responds to overcrowding of psychiatric patients in New York City Health and Hospitals Corporation facilities in Manhattan and the Bronx. It is a stop-gap measure which does not address the underlying problem of treatment for the mentally ill or the basic relationships between state and city hospital care. "Clearly the quality of patient care suffers under this arrangement and accountability is weakened while state hospitals are overburdened."[22] The agreement is mentioned only as an example of the weakness inherent in the management of the mental health system serving New York City which would require such an agreement at all. The lack of clarity regarding roles and responsibilities of the state and the city, each with competing and often conflicting objectives, is the focal problem of system management. This problem is endemic throughout the state although its impact on quality services to clients varies considerably from one locality to another.

In addition to problems of intra-system coordination, there are significant difficulties with coordination between the state-local mental health system and generic human services. For example, decisions which may pertain to housing for the mentally ill are often made unilaterally by state and local government agencies in an administrative environment with little or no input from mental health agencies. One clear example of this problem is the establishment and certification of private proprietary homes for adults (PPHAs). PPHAs are congregate residences certified by the State Department of Social Services. Initially targeted for a generally frail elderly population, PPHAs in some areas have become a significant resource in housing persons with chronic mental illness. The evolution of a significant subset of PPHAs for the chronically mentally ill has been, in essence, a marketplace phenomenon rather than one shaped by state policy. The resulting mix of populations poses serious problems for the State Department of Social Services in regulating these facilities, and has led to less than desirable mental health services for thousands of persons in need. What is needed is a reexamination of State Department of Social Services and Office of Mental Health roles in regulating the quality of living environments for chronically mentally ill persons residing in Department of Social Services congregate care facilities.

The question, "Who is in charge?" is not simply a rhetorical device, but a fundamental unresolved issue. The diminution of the state's role as a provider, the concomitant growth of the local public and voluntary provider sectors, and the multiplicity of funding streams continue to make the question unanswerable. Article 7 of the Mental Hygiene Law declares that "the State of New York and its local governments have a responsibility for the prevention and early detection of mental illness and for the comprehensively planned care, treatment and rehabilitation of their mentally ill citizens." The law further states that the Office of Mental Health is responsible to see that all mentally ill persons receive care, and that their personal and civil rights are protected. It further directs the Office of Mental Health to train personnel, to regulate and control quality care, to develop comprehensive plans and to conduct research. At times, this law has been interpreted as charging only the state and not other levels of government with responsibility to assure appropriate care for the mentally ill. However, Article 41.13 of the Mental Hygiene Law charges local governments with many of the same responsibilities. As a result, definitions of state and local government responsibility have become ambiguous and subject to different interpretations.

E. Planning— The Missing Essential

Mary Jane B. is 60 years old. She has spent virtually all her adult life in a psychiatric center. She was well adjusted to institutional life. As part of deinstitutionalization, Mary Jane was discharged to an adult home but she didn't like her roommate and didn't believe the home fed her adequately. She left and started roaming the streets, eating irregularly and sleeping where and when she could. She wandered into a church where concerned persons called the psychiatric center which suggested they call the outpatient clinic. The clinic, in turn, refused to send a health worker. Mary Jane left and wandered on, her inner voices becoming louder. Her case demonstrates the need for linkages among mental health services and other human services.

New York State government, through the Office of Mental Health, is responsible for the establishment of a comprehensive system of mental health care for all its residents. The blueprint for such a system does not now exist, and responsibility for such a plan is not within the historic understanding of the Office of Mental Health's mission. During the early 1980s, successive five-year comprehensive plans were written, but had little relation to those which preceded them and offered little promise of achieving the level of coordination, integration and accountability necessary to succeed.

The mental health plan development process has not done justice to the multiple organizational roles and responsibilities of the Office of Mental Health. Plans have not addressed in detail an overall strategy for moving the public mental health system in a particular

direction. Among the missing planning elements are: population-based service need estimates; a model of basic and complementary services; an accepted definition of public and private agency roles, and statewide standards for availability and accessibility of services.

Consequently, the Office of Mental Health's 5.07 Plan (Section 5.07 of the Mental Hygiene Law) has focused on short-term government activities and budgetary concerns (less than two years duration) with overemphasis on the allocation of state funds and neglect of strategic planning that might achieve a truly rational and integrated system. The Office of Mental Health has made significant progress in tying annual administrative planning and budgeting together in its annual planning process but the broader context in which the document fits has not yet been delineated.

4 Principles

GOVERNOR CUOMO'S CHARGE to the Select Commission was to propose concrete recommendations to improve the delivery of care, establish a more effective working relationship among the state and local governments and to restructure the financing mechanisms that drive the public mental health system. The previous section of this report described many of the obstacles and dilemmas inherent in the current system. In order to address these problems, the Select Commission first agreed upon several guiding principles that provide a context from which specific recommendations may emerge.

The 15 principles are organized into five categories, namely: services and program development, finance, management, planning, and research and evaluation. The following section of this report—that which contains the recommendations—is similarly organized.

One of the basic underlying assumptions which governs these principles is the recognition that the public mental health system is not capable of providing a full range of services to everyone who might benefit from them. Although significant additional public funding will be necessary, realistic fiscal constraints do not allow for the design of a system that may ultimately cost considerably more than the $2.3 billion currently expended by the public system. Hard choices are necessary and we strove throughout our deliberative process not to avoid them. We endeavored to fashion a new, integrated system of quality care for those in our "family of New York" who need these services the most and have the fewest alternatives to receive them outside the public sector.

A. Services and Program Development Principles

PRINCIPLE ONE

It is incumbent upon the public mental health system to provide a comprehensive array and a full continuum of services necessary to meet the needs of persons who are mentally ill or are vulnerable to the development of mental illness. Linkages among all components of the public mental health system are also necessary to assure continuity of services. (See recommendation one)

The public mental health system should make available and accessible a comprehensive array of mental health programs and insure that these programs meet the mental health needs of a geographic area. Furthermore, there should be a gradation of inpatient and non-inpatient services which are appropriate to meet the varying levels of patient disability resulting from mental illness. This continuum of service should result in a system of care that provides for continuous levels of care between institutions and community programs, as well as within service programs, e.g., different levels of community residence programs, ranging from those that are highly supervised to those that provide for greater independence.

The system of care must provide for continuity of services and patient care. In addition to the structural components of the system—comprehensiveness, accessibility, availability and effectiveness of services—it is essential to have a system of care that provides for orderly, uninterrupted movement of patients among the different elements of the mental health and human service systems. Incorporating those dimensions of a service system that support the movement of patients into service elements that will meet their changing needs and levels of functioning is the fundamental principle underlying continuity of care.

The mentally ill, especially those with serious and chronic illnesses, should be provided with a well-coordinated and effective array of services. Case management, which links patients to generic and mental health services, as well as adequate housing, income maintenance and vocational training, should be the cornerstone of accountability in the system. The intent is to fix responsibility to a single agency that will refer, monitor and advocate for the individual patient and his/her multiple needs.

PRINCIPLE TWO

It is essential that public mental health services be available and accessible to individuals of all cultures and be responsive to their special needs. (See recommendation one)

Mental health services should be available and accessible to mentally ill persons of all ages, ethnicity, socioeconomic and cultural backgrounds and disabilities. Mental health services should be designed and staffed

to respond effectively to the needs of special populations, particularly children, minorities, young chronics, the physically disabled, the elderly, the multiply disabled and the medically indigent.

PRINCIPLE THREE

Public mental health services must be equitably distributed to address population need and reflect geographic variations (See recommendation one)

A system of mental health care should be provided to insure that resources and services are equitably distributed to populations and geographic areas. Inherent in the concept of equity is assuring that not only are sufficient resources available to meet the needs of the mentally ill, but these resources are also available in a consistent manner. Guidelines for use of resources which are flexible to meet geographic needs and can be deployed in a manner to meet population priorities are also necessary.

PRINCIPLE FOUR

Only those programs that are based upon need and effectively provide a minimum level of quality care will be supported with public funds. (See recommendations one and two)

Population-based program, process and outcome standards to determine the type, quantity, quality and effectiveness of services used by the population of a given geographic area should be developed. When available, these standards should guide the planning and resource allocation process. A mechanism to monitor the quality of patient care is also needed to encourage effective treatment modalities and appropriate use of limited financial resources. A needs assessment process should be developed by the Office of Mental Health as a first step in moving toward a realistic monitoring system.

PRINCIPLE FIVE

It is essential that there be integration between the public mental health system and necessary generic health, housing and social service systems to link the various providers into a total human service system. (See recommendation one)

This principle insures that all essential support for daily life is brokered from other human service and housing agencies and is fully integrated into a single treatment plan. In addition, to ensure that the unique needs of special population groups such as children and youth and the elderly are addressed in a comprehensive manner, public mental health services and facilities should be integrated with the educational, juvenile justice, health, welfare, social service, mental hygiene, housing and aging systems.

PRINCIPLE SIX

The public mental health system must emphasize the importance of prevention and early intervention services and coordinate the administration and delivery of these services with those of other service delivery systems. (See recommendation one)

Prevention services are an essential component of a comprehensive mental health service system. Attention should be focused not only on those who are currently patients in the system, but also on those who, with effective prevention services, can avoid the necessity for long-term intervention. Therefore, funds should be clearly designated for the purposes of prevention and early intervention. Special population groups such as children and youth, minorities, and the elderly will particularly benefit from prevention services.

PRINCIPLE SEVEN

Formal and informal supports to families must be encouraged by the public mental health system. (See recommendation one)

There is growing evidence that families are under significant stress in their attempt to care for mentally disabled family members. This principle addresses the important role of the mental health system in providing support to families which would reduce these stresses, enhance their parenting and coping abilities, and reduce the need for out-of-home placement.

PRINCIPLE EIGHT

The public mental health system should provide sufficient training and incentives to insure successful recruitment of personnel sensitive to cultural and ethnic differences among its clients. (See recommendation one)

There should be an effective recruitment and training effort for professional and nonprofessional personnel that insures the deployment of staff sensitive to the different ethnic, cultural and social characteristics of the population served. It is likely that such training and initiatives will vary from region to region and be targeted to the specific needs of each mental health region.

B. Finance Principles

PRINCIPLE NINE

Financing of mental health services must be based on the principle of consolidating multiple sources of funding. (See recommendations three and four)

This principle stresses the importance of minimizing the complexity of the present "patchwork" approach to funding services. This approach too often confounds providers and clients alike. The administrative burden

of dealing with detailed, sometimes conflicting, rules, regulations and procedures diverts effort from the central responsibility of assuring effective patient care. The numerous categorical funding sources available often act as impediments to care rather than as incentives.

PRINCIPLE TEN

Funding a full range of services is necessary, based on a formula approach which takes into account functional needs of patients, geography served, demographic variables (including poverty, ethnicity/culture) and price differentials. (See recommendations four, five and six)

This principle addresses two separate issues; the aggregate level at which funding is set by state policy and the mechanism by which funds are distributed to localities. The former implies a legislative choice with respect to fixing the level of annual systemwide expenditures or to providing for entitlements for the care and treatment of the mentally ill. The latter implies modification of the present approach, which allocates state funding based on historical patterns and the limitations imposed by a myriad of categorical programs.

The Select Commission emphatically wishes to guarantee and protect the aggregate level of state mental health funding from annual political intrusions. In addition, it wishes to establish a more equitable approach to the distribution of available funds throughout the state. To assure such equity, a legally protected formula-based funding system is deemed essential.

C. Management Principles

PRINCIPLE ELEVEN

Consolidation of funding must be accompanied by consolidation of control through local managements. Every mental health region must have a single focal point of fiscal, programmatic and administrative control and accountability. Local management must also be responsible for insuring patient-specific case management. (See recommendations seven and eight)

This principle addresses the concept of decentralized management and authority of the local mental health system. The state might better be divided into a number of county-specific or multi-county regions. A local mental health management would become the operational manager and/or contractor for all mental health services in the geographic area served by the local management. Local managements would govern the service system for those at risk of or with a mental disability.

PRINCIPLE TWELVE

The Office of Mental Health must stimulate the development of an effective community-based care system; regulate, plan for and guide the entire public mental health system; and provide for the operation of state psychiatric centers and their programs. The Office of Mental Health should be so organized as to separate these functions. (See recommendation eight)

The Office of Mental Health should have three principal functions: (1) the regulation, certification, funding and direction of New York's public mental health system; (2) the stimulation of a comprehensive and properly balanced system of care, and (3) the direct provision of services through state psychiatric centers. This last function has historically received a disproportionate amount of staff energy and resources and must be segregated administratively in order to assure that the first two functions are carried out properly.

PRINCIPLE THIRTEEN

It is appropriate and necessary to utilize the state psychiatric center work force in the community care system while utilizing the local government and private sector mental health work force efficiently and effectively. (See recommendation nine)

This principle underlines the importance of utilizing state psychiatric center employees in the growing community-based care system regardless of the auspices under which services are to be delivered—state and local governments or voluntary agency contractors. The state psychiatric center work force possesses the necessary expertise to deliver quality care to the seriously mentally ill. Their invaluable experience and specialized skills can readily be transferred to smaller or more decentralized programs in the community. In addition, the local government and private sector mental health work force should be allowed access to state employment as the need arises.

D. Planning Principle

PRINCIPLE FOURTEEN

It is necessary to have a strategic planning process that encompasses both state policy direction and active local participation. This process must be closely related to consolidated financing and management. (See recommendation ten)

An effective long-range planning process for mental health system design does not exist in New York. There is an elaborate array of councils and planning bodies at the state and local levels, but they do not function as part of an effective and integrated planning process. In addition, there is insufficient staff within the Office of Mental Health assigned to this vital activity.

The only planning now carried out is "de facto" administrative planning and is, at best, a component of the annual state budgeting process. Administrative planning is no substitute for a population-based planning process which specifies, in quantifiable terms and by region, the minimum necessary levels of service for tar-

geted populations. Strategic system planning should drive the budgeting process and be fully integrated with local managements.

The planning process for the delivery of public mental health services should be coordinated with the planning processes of the other health and human service systems. The development of a coordinated interagency planning process within the overall service delivery system is essential in order to maximize resources, use existing funds cost-effectively, meet the specific needs of the population within a given area, and avoid gaps or duplication in services across systems.

E. Research and Evaluation Principle

PRINCIPLE FIFTEEN

An active research and evaluation program is an essential component of a public mental health system. (See recommendation eleven)

The Office of Mental Health should promote research efforts that identify factors contributing to mental illness, assess the relative value of different therapeutic interventions which may alter the course of an illness, and insure the dissemination of new knowledge throughout the mental health system. Uniform data collection and dissemination regarding the size, characteristics, service utilization and cost of services to the mentally ill are also necessary and could be useful to researchers.

5 System Design and Reform Characteristics

THIS CHAPTER IS DIVIDED into two components. The first is a brief discussion of four assumptions that have compelled the Select Commission to limit its redesign of New York's mental health system. These assumptions, identified at the onset of the Select Commission's activities, are viewed as parameters for the decisions we hope will lead to the recommended changes.

The second component is a thorough discussion of the Select Commission's recommendations. These recommendations emanate from and reflect the intent of the 15 principles discussed in chapter IV. As in chapter IV, a system design framework is used to organize the presentation of individual recommendations as follows: services and program development, finance, management, planning, and research and evaluation.

A. Assumptions

The recommendations of the Select Commission reflect a sense of pragmatism or realism tempering idealism. In constructing the design of a modified public mental health system, it was necessary to accept basic assumptions about the nature of the environment within which the current system operates. The assumptions highlighted below are statements of the realities which must be taken into account in making systemic changes in New York's public mental health system.

Multiple Auspices

New York's public mental health system is diverse. The historical evolution of three strong auspices for programs— the state, local governments and the voluntary sector—has resulted in a unique configuration compared to most other states we examined. The level of diversity is varied throughout the state. In some areas the voluntary sector or county government is predominant, in others the state; but all three sectors participate strongly when viewed from a statewide perspective. By acknowledging this as a potential strength, although to date it has posed serious problems for systemwide coordination, we have chosen to incorporate this historical legacy in arriving at our recommendations—thereby insuring a continuing role for providers from each sector.

Fiscal Limits

Fiscal constraints dictate that the public mental health system cannot address the total mental health needs of all of the state's citizens. New York's budget for mental health care is the largest in the country, on a per capita basis and in the aggregate. It is unrealistic to expect an immediate, dramatic increase in public spending for mental health, although a substantial augmentation of state funding will be necessary over the next decade to allow the system to develop into one that is capable of properly caring for the state's most seriously ill citizens. An initial and significant sum of state financing will be necessary to "front-end" the development of an effective and viable system of community-based mental health care. Significant "front-end" funding will have the long-term impact of changing the locus of care from the hospital to the community, where care is less expensive and often more appropriate for many of New York's mentally ill. The availability of adequate community-based resources will ultimately relieve many of the pressures to hospitalize mentally ill individuals.

Security of the Work Force

The Select Commission recognizes the need for a continuing commitment to the maintenance and promotion of a professional public mental health work force for both inpatient and community-based services.

New York has historically had a large fiscal and manpower commitment in the provision of public mental health services. The first state hospital, Utica Insane Asylum, opened its doors in 1843. As demands for inpatient care increased, the state built more and larger hospitals. Today, 23 adult facilities, six children's psychiatric centers and two forensic facilities employ more than 37,000 individuals in health, mental health, social work, nutrition, business administration, engineering and allied fields.

The state employee work force represents a competent and highly trained resource committed to the care and treatment of the mentally ill. Most of these employees are represented by public employee unions. Since more than 80 percent of the state psychiatric center operational costs are spent on personnel, the impact of any decision that may affect the status of these employees is very significant. Therefore, in recognition of the importance of the mental health work force, the Select Commission's recommendations call for no layoffs of state staff and advocate the fullest possible continuity of employment for all employees (state, local and voluntary), even though part of the state work force may need to be gradually transferred to a community-based system of care. The impact of proposed changes

on county, city, state and voluntary sector employees must be carefully assessed to minimize pain and disruption to the families of these workers.

Timing

The external expectations for the Select Commission's recommendations to change the public system of mental health services in the state vary considerably. Some would ask for overnight change. As described in chapter III, the scope and intensity of the service delivery, finance and systems management problems are dramatic and very complex—even overwhelming. The Select Commission, therefore, acknowledges that many years will be necessary for recommendations to have a significant impact on changing the system. Implementation of the recommendations will be introduced according to a strategic plan of action (see chapter VI) that will, hopefully, result in a minimum of disruption. It is also necessary, as we proceed, to change behavioral patterns and beliefs throughout the system. In so doing, it will be necessary to insure that the new directions charted will be sustained over the many years required to achieve profound systemwide change. The public must be educated to the realities of mental illness, the herculean efforts that many dedicated professionals and families must make to treat or even stabilize the conditions of some seriously ill patients, and finally, the realities of the expenditures necessary to care for them humanely.

B. Recommendations

The following recommendations have been divided into five categories, namely: services and program development, finance, management, planning, and research and evaluation. The recommendations require that new resources be provided from the state to both augment the community-based system of care and enhance the quality of care rendered at state psychiatric centers. The recommended course of action is additive rather than one of substituting community-based care for long term inpatient care.

In lieu of dividing a budget presentation among each of the recommendations, Appendix E provides a centralized reference depicting the major cost requirements associated with the report. These are *proposed* requirements that should be used as a basis for understanding the overall financial implications of the report.

1. SERVICES AND PROGRAM DEVELOPMENT

RECOMMENDATION ONE

The state should provide for the local delivery of a complete spectrum of basic services, including case management, to the mentally ill of all ages.

(a) The Office of Mental Health should ensure that a complete spectrum of basic services is both available and accessible throughout the state. Such services should include crisis services (as well as mobile crisis services) with the capacity to care for the patient throughout the crisis episode; acute hospital care; intermediate and long-term hospital care; residential programs; non-residential alternatives (day and continuing treatment, psycho-social services, etc.); clinic services; prevention and education programs, and case management.

The Select Commission wishes to note that problems of accessibility are greater in some population groups, such as ethnic minorities, who often encounter language and cultural barriers. In addition, patients presenting difficult diagnostic and treatment options such as the forensic population, the dually diagnosed, young chronics and the homeless also meet with significant barriers.

Mentally ill persons can be classified in a number of different ways. The most useful manner, in terms of service need, is to classify them by age and severity of mental illness. It is important to point out that mental health service needs are affected by a number of factors, including, age, degree of illness and demographic, geographic, ethnic and racial characteristics of the state. The combined effect of these factors may result in variations in the configuration of basic services from area to area. The work necessary to describe the unique service needs of a given geographic area requires the development of needs assessment methodologies described in another section of this report.

Recommendations regarding required statewide services for the children and youth, adult and elderly populations are as follows:

Children and Youth

- Inpatient services (including residential treatment facilities), day treatment, outpatient clinics, services to support families caring for mentally ill children and youth, diagnostic and evaluation services, and prevention and early intervention services for high-risk children and youth should be available and accessible.
- Agreements should be developed between the mental health system and other children and youth—serving providers within each mental health region so that children and youth ready for discharge from OMH-operated or certified residential programs, but not ready to return home, can have access to residential services provided through the social service or education systems. The public mental health system should, in turn, provide consultation, evaluation, and crisis back-up services for providers serving mentally ill children and youth.
- Agreements should be developed between the public mental health system and other children and youth service systems for the provision of mental health diagnosis and evaluation services at the point of intake into these systems. This, as a minimum, should include agreements between the mental health system and the family courts, the local social service districts, and the local school districts within the region.

- The public mental health system must focus attention on childhood as a period of continuing and rapid developmental change and on the need for intervention strategies that support youth in family settings. The programmatic emphasis should consistently be on developing and fostering family support services.
- A two-year state task force should be established to focus on interdepartmental issues impeding the delivery of mental health services to children and youth.
- The April, 1984 Office of Mental Health "Multi-Year Plan for Children and Youth Mental Health Services" is an excellent first step toward a more comprehensive and intelligent approach to the provision of mental health services for those under 18. The recommendations contained in this plan should be given full consideration by state government. Appendix A expresses a number of goals and objectives from this plan which the Select Commission supports.

Adults

- A comprehensive range of services, especially for chronically mentally ill adults, including: community residences, crisis residences and intervention, case management and day programs (day and continuing treatment, day training, psycho-social clubs and sheltered workshops) are the primary building blocks of a community-based service system. In some areas of the state these services will need to be newly created, in others, simply expanded and made more accessible.
- Programs that will increase the likelihood of mentally ill patients entering the employment market should be supported and expanded. Fountain House in New York City has experienced a high degree of success in this regard. Other initiatives undertaken by the State Offices of Vocational Rehabilitation and Mental Health also justify future support.
- Adequate long-term and acute care inpatient beds, outpatient clinic care and transportation are among the programs most in need.
- Where appropriate, the emphasis of programs should shift from individual treatment toward individual rehabilitation which would assist clients to behave appropriately in group living situations and community settings, and to re-learn skills lost during hospitalization or street life. All services should be rendered in a safe and supportive atmosphere, with the goal of providing those residents who are capable of living independently with job skills and other independent living skills. Those residents who will always need the supportive environment of a group living situation, such as an adult home, must continue to be provided with programs appropriately tailored to their individualized needs.
- Existing levels of service must also be maintained for non-chronically mentally ill adults.
- One sub-group of the adult population that presents major demands upon the mental health system is *the young chronics.* Due to their condition they are likely to be rehospitalized periodically or to suffer isolation and deprivation in the community. Needed services for this group include: social, recreational and supportive work programs coupled with special outreach and follow-up efforts to engage them over a sustained period of time. Psycho-social "clubs," evening/weekend recreational activities, and supportive work experiences are particularly valuable for this group. Unstructured activities to at least engage these difficult-to-serve persons in minimal levels of service should, when combined later with more assertive case management, lead to a better chance of re-socialization and eventually enhance the prospects for semi-independent living.

Elderly

- **Outreach services**–Too often professionals expect clients to voluntarily seek help and arrange services. But the elderly person facing, in many cases, limited mobility, lack of transportation, fear or limited knowledge of available mental health services cannot fulfill this expectation.
- **Inclusive screening procedures**–An overall evaluation of the aged client can provide more accurate intervention into health problems, both physical and psychological. The elderly mentally impaired usually require mental health and other generic human services. The delivery of one can offset a more extensive need for the other.
- **Comprehensive case management**–There is a need for better follow-up and linkage with supportive generic services to ensure that available resources are utilized to their fullest potential. Care, once initiated for the mentally impaired elderly, must be carried through to an acceptable conclusion in all areas of service needs.
- The provision of **day care, outpatient treatment** and **respite care** is essential to assist families and encourage family support groups.
- **Expansion of mobile geriatric teams (MGT)**–The initial evaluation and referral services of MGTs has proven effective with the mentally impaired elderly. However, the availability of MGTs is not uniform, nor are the standards of service provision under which they operate. Development of more MGTs for both evaluation and home treatment of the homebound elderly client is necessary.
- **Greater attention to high risk cases within the geriatric population**–This would include services directed specifically at groups such as those recently widowed, those persons with a previous history of mental illness, and those facing an unexpected loss or crisis situation, with a preventive focus on treatment.
- **It is essential to target community residence programs and continuing treatment programs to the mentally impaired elderly** who will be impacting on the mental health system dramatically. These mentally impaired elderly are not able to live independently, although they are likely to be physically healthy. Supervised living arrangements in the community should be made available in order to offset the purposeful denial of

access to long-term psychiatric center inpatient care for the elderly.

- **Rejection of the myths and stereotypes of aging**—It is necessary to educate and train treatment staff and mental health planners as to the symptoms of aging (both physical and psychological). Viable treatment strategies and available resources can help providers erase the kind of therapeutic pessimism that results from the lack of noticeable or immediate treatment effects.
- **State psychiatric centers should become better organized and equipped** to handle short-term admissions of elderly patients for whom return to the community, though difficult, must be managed expeditiously and with special expertise in aftercare planning. This applies particularly to the estimated 10 percent of the state's elderly population suffering from depression. These persons are often isolated, rejected or misdiagnosed when, in fact, they have a reversible illness. Brief hospitalization stays are frequently indicated.

The Office of Mental Health and local managements should assure that appropriate levels of funding are available to address the service needs of the above populations to remove financial barriers to care.

In addition to the three age populations, the service needs of several additional subgroups must be addressed as follows:

- **The Homeless:** The Select Commission was aware that the Governor's Task Force on the Homeless, as well as a special Interagency Task Force convened by the State Department of Social Services, were simultaneously issuing special reports during the same time frame as the Select Commission's own deliberations. It was also aware of the significant and important recently issued findings of the American Psychiatric Association with respect to the homeless. Its emphasis, in contrast to the vital work of these bodies, was to devise concrete systemic reforms that will impact significantly on the plight of the homeless mentally ill in particular, including the runaway and homeless youth. The recommendations of the Select Commission will, hopefully, greatly improve their opportunities for gaining access to crisis intervention, outreach, case management, and generic health and human services, and most importantly—supportive housing.

  Several key recommendations of the report, when fully actualized, should dramatically enhance the prospects for engaging homeless mentally ill persons. The services they desperately require will be established and expanded as would the pool of supportive housing options.

  First and foremost, the establishment of 100 percent state-funding for all system dependent or population II patients should enhance the potential for a large percentage of homeless mentally ill persons to gain access to care. It will provide a major incentive for local managements to seek them out regardless of their current habitat. In essence, unlike the fault-passing that has tragically characterized the history of public policy between the state and local governments until very recently, the proposed system would encourage a local management to actively find and engage in a full spectrum of services for the homeless mentally ill. An annual capitated dollar amount would become available to local managements for each homeless person meeting the eligibility criteria described for population II. (See recommendation three). Such a positive incentive to reach out and engage previously unserved individuals has simply not existed to date. Once identified and qualified under such a funding scheme, it would be incumbent on the Office of Mental Health to carefully monitor the service provision and continuity offered each homeless individual by the local management.

  As New York City's Project Reach-Out in Central Park and other mobile outreach teams operating around the state have found, the homeless mentally ill require repeated and persistent attempts to engage them successfully in programs and potential shelter and/or housing. The addition of 2500 new case managers statewide should greatly extend the capability for deploying sufficient mobile outreach teams to reach the thousands of previously unserved homeless persons living on the streets, as well as those already staying in municipal emergency shelters.

  Recommendation Five establishes a capitalization assistance program that should greatly increase the funding available from both the private and public sectors for capital costs of acquiring, renovating and in some cases constructing new facilities for community-based programs and residences. We envision new residential modalities beyond those currently provided by the community residence program to become more widespread as a consequence of finally addressing the "capitalization" hurdle that many potential voluntary sponsors of supportive housing, day treatment, psycho-social clubs and other community-based day programs have been unable to surmount to date. Again, in New York City, the proposed residential care center for adults on the grounds of Creedmoor Psychiatric Center, the St. Francis Residences, and the continuum of residential options provided by the Westside Cluster in Manhattan, ranging from the Olivieri Drop-In Center to the Traveler's Hotel, all serve as useful potential models for statewide replication.

  We do not underestimate the tremendous energy and compassion that will need to be employed by outreach teams and new case managers. Multiple attempts at services engagement will be necessary over a very protracted period of time to overcome suspicion and fear. A greater availability of creative drop-in centers, where the stigma of accepting care is made considerably less frightening than many municipal emergency shelters, will be particularly useful in addressing this fragile population.

  Socialization skills may be slowly relearned and linkages to appropriate services and residences eventually made through these centers.

The task is enormous, but the systemic management and fiscal reforms articulated by the Select Commission could prove to be particularly beneficial to this neglected sub-group of the unserved mentally ill.

- **Minority Populations:** A significant and predictably growing number of the patient population are Black, Puerto Rican and other minorities. The Office of Mental Health's 1982 patient characteristic survey revealed that a large percentage of minorities use the public mental health system (27.2 percent of total users.) By contrast, there are relatively few minority professional providers in the system. Given that there are known ethnic differences with respect to prevalence patterns, help-seeking patterns, use of support networks, efficiency of treatment approach, etc., the goal of accessibility to effective services for all needs to be furthered through initiatives in several key areas. Policies that promote the provision of bilingual-bicultural and culturally-sensitive services within existing programs should be encouraged. Initiatives toward the recruitment and promotion of minority group professionals (especially at policy and management levels) should be more forcefully pursued.

  As an area of growth, there is need for enhanced research and training to facilitate the dissemination of available knowledge about treatment efficacy with minorities and training of professionals to work with the minority urban poor. As the needs of minority patients often cross boundaries into other systems such as forensics, social services, health and education, support of interagency coordination to creatively address these problems is important. In addition, prevalence patterns among minority populations suggest the need for population and problem-focused prevention and education efforts to reach significant segments of the minority population in need.

- **Forensic Population:** The Select Commission decided not to address the entire realm of forensic mental health service issues because this would require a very lengthy and intensive investigation by itself. We do not wish, however, to underestimate the complexity and seriousness of problems that must be addressed in this area of public policy. Rather, it is felt that the Governor should seek advice from a different set of experts, including appropriate representatives from correctional agencies, to better serve such an inquiry.

- **Multiply Disabled:** The multiply disabled mentally ill includes the retarded, substance abusers, and the physically handicapped. At present their needs are not being met. Many of the multiply disabled are excluded from community residences and day treatment centers. They need assurance that their right to treatment is the same as that of persons with a single disability. They deserve acceptance in community programs unless a tendency toward violence would make their presence a danger to others, which is very rarely the case. Special programs are needed for those who require care beyond that presently provided.

  There are three sub-groups of this population, as follows:

  The Mentally Retarded and Developmentally Disabled—The retarded mentally ill are seldom admitted into community treatment centers and residences. They are considered too disruptive for the residences designed for the retarded, and too retarded for services designed for the mentally ill. Many who would be capable of community living if suitable services were available reside in state hospitals. Others are cared for at home by parents who may be able to do very little for them, but who are sacrificing their own lives in the attempt. Where possible the mildly retarded mentally ill should be treated in the same treatment centers and residences as other mentally ill persons. Special residences and treatment centers should be provided for those unable to fit in to the facilities designed for the mentally ill.

  Alcohol and Substance Abusers—Persons with schizophrenia or manic depressive illness often seek street drugs such as alcohol or marijuana to relieve their misery. Selected studies of the young adult chronics show that over 50 percent in Rockland County and 25 percent at Hutchings Psychiatric Center are substance or alcohol abusers. In some cases it is not clear whether the primary diagnosis should be mental illness or substance abuse. At present, substance abusers are usually barred from community residences, and often from day treatment programs. In addition, many are drifters on the street because there are no programs to meet their needs. It appears that most substance abusers can spend the greater part of their day in a program designed for patients who are not substance abusers, if they are supervised during the remainder of the day and night to prevent their acquisition of drugs or alcohol, and are at the same time educated about the long term effects of these drugs on their illness.

  The Physically Handicapped—The physically handicapped who are mentally ill can, in most cases, be included in the community facilities used for those who are only mentally ill. In most facilities, structural adaptations to meet their needs are already in place. Those requiring special assistance can often be aided by physically healthy patients to their mutual benefit.

  Conclusions—It is important that every person, whether singly or multiply disabled, be looked upon as an individual and be provided individualized treatment. Case management and outreach are appropriate models and should be made available to all multiply disabled individuals. A case manager knows the patient well enough to determine the kind of treatment and residence that will best meet his needs. It is also extremely important that difficulties be avoided in determining which agency or department should be responsible for the multiply disabled. The Governor should initiate an interdepartmental effort to assure that this population does not continue to be underserved.

- **Rural Populations:** The accessibility and availability of mental health services in rural areas of New York State present a unique challenge to the public mental health system. Often individuals are isolated, and due to inadequate or non-existent public transportation, services are virtually inaccessible. In addition, climate and topography often play a major role in minimizing opportunities for adequate identification and treatment of symptoms. Outreach and crisis services, especially mobile services, are urgently needed in rural areas, which constitute a vast majority of the state's geography. The Select Commission recommends that variables taking rural problems into account be included in the development of needs assessment methodologies and funding formulas. In addition, the present strengths of local planning should be carried forward and utilized in the newly proposed system of planning (See Recommendation 10).

(b) The Office of Mental Health, through its regulation of local managements,* should insure that a strong and effective case management system is in place throughout the state for the entire system dependent population** and those in the periodically served population** requiring such services. It is through case management that the local management can address its primary responsibility, namely, that of being held fully accountable for each of its clients. Within a reasonable number of years it should be possible to have reliable and updated information concerning the progress of any patient through a rationally designed continuum of care.

Case management involves three distinct levels of service. The first occurs at the provider level, as it is a component of the treatment process. It involves patient-specific clinical assessment of the client's mental health care needs. Development of and periodic modifications to the patient's treatment plan, as well as responsibility for discharge planning, where it is applicable, are appropriate provider case management functions.

The second, provided through a computerized management information system, is a monitoring function which should be the responsibility of the local management. This involves application of the Office of Mental Health's automated data base to insure that all aspects of the patient's treatment plan are being fulfilled. The patient's progress, as determined by his/her movement through the continuum of services, as well as exit from and re-entry into the system, can be fully monitored in this manner.

The third level of service entails three distinct functions as follows:

(1) Client advocacy and assistance for arranging housing, health, employment and income support, as well as nutrition, vocational and educational programs;

(2) Coordination and effective use of the human services system to remove barriers to services, including mental health and health care, mental hygiene, education, aging, housing, employment and income support; and,

(3) An outreach component so that emotionally fragile clients can be visited in the community to provide encouragement and support. This level of support will improve the likelihood for the client's continued involvement with the mental health service system, assist patients to cope with their illness and maximize their capacity to be useful members of the community. It will also enhance the potential that the client will gain access to the employment market as employment has been shown to be an effective incentive for the client to remain in the community.

The responsibilities of case management may be carried out by a direct service provider, a core case management agency, or the local management. The Select Commission finds that to recommend only one of these would prematurely limit the flexibility required to plan for successful case management on a statewide basis. As long as all three levels of case management are present in a coordinated manner, and the local management is held fully accountable, the source of the third critical function may vary among mental health regions. Case management may be provided by both professionals and paraprofessionals. The level of professionalism may vary from region to region and according to the function to be served. Client confidentiality and the rights of patients must be adhered to at all times by case managers.

(c) The Office of Mental Health should amend and/or develop new recruitment and training policies and modify mental health programs at state and local levels to more effectively reach the minority populations and address the forensic population.

RECOMMENDATION TWO

The Office of Mental Health should develop standards to ensure appropriate local service configurations, basic adequate program requirements and effective service outcomes.

(a) The Office of Mental Health should establish and maintain appropriate population/program standards. These standards require the development of needs assessment methodologies to determine the required minimum and maximum amounts for all residential and non-residential services. Criteria would be developed to permit localities the flexibility to determine their own service configuration. These criteria would be developed by the Office of Mental Health with other public and private sector input to reflect population characteristics such as age, socio-demographic, cultural

*See recommendation seven for definition and responsibilities of local managements.

**See recommendation three for definition and description of population groups.

and ethnic, and economic aspects—all within statewide guidelines—to insure equity as well as flexibility to respond (within a defined framework) to unique community characteristics.

(b) The Office of Mental Health should redesign and maintain process standards to define the basic requirements necessary to carry out a program. These standards should address staffing, patient characteristics, training resources and admission, continuing stay and discharge criteria. Throughout this process the rights of patients and the confidentiality of records should be fully protected.

(c) The Office of Mental Health should establish and update outcome standards (the expected results of treatment), such as the level of anticipated improvement, to ensure effective care and accountability. Appropriate service outcomes should include: stabilization of symptoms, prevention of relapse and an improvement in social and instrumental functioning to the optimal degree possible for each individual.

2. FINANCING

RECOMMENDATION THREE

For purposes of financing, the population using the public mental health system should be divided into three separate population groups, with appropriate definitions and eligibility criteria for each.

(a) Population Definitions

(1) Population Group I– Current Long-Term Inpatient Population

This population is the state's long-term care population who have depended upon the service and environment found in either state psychiatric centers or Office of Mental Health licensed family care programs. All individuals who have continuously resided in either setting for several years (e.g., three years, five years, etc.) will be assigned to population I. A precise definition of this population should be made by a *panel of clinical experts* to be appointed by the Office of Mental Health. Advice from a broad range of providers and consumers should be sought by the Office of Mental Health prior to announcing the membership of this panel.

Population I will be established as a discrete group on a given date (e.g., 1/1/86) and may not subsequently be augmented with new patients. Patients who are not initially eligible for population I will be financed pursuant to populations II or III. Population I patients will be moved into population II if they are capable of residing in other living situations. The Select Commission fully recognizes that there will be a continuing need for long-term state psychiatric center care for patients in population II.

(2) Population Group II– System Dependent Population

This population is comprised of those individuals of all ages who are seriously and persistently mentally ill, requiring long-term supportive mental health care, including long-term inpatient care. Individuals in this population may presently live in the community or reside at a state psychiatric center.

The system dependent mentally ill population should consist of those individuals who, by clinical assessment, meet criteria in each of the following three areas: diagnosis, disability and duration of illness. These criteria, which are more fully discussed in Appendix B, should be precisely defined by the Office of Mental Health and the *panel of clinical experts* previously noted. The Office of Mental Health should develop an eligibility process to provide for initial access to population II. It must be emphasized that this eligibility process must not exclude any individual as a result of age (e.g., children). For example, the duration criterion must specifically allow for inclusion of children who are otherwise eligible diagnostically and functionally. The Office of Mental Health should also provide for periodic re-examination of individuals in population II for continued eligibility by the respective local management. This periodic re-examination process should not, of necessity, require face-to-face contact with each population II client. Rather, re-certification may be made as a result of a clinical review of the client's treatment plan. The Office of Mental Health should be vested with the responsibility to fully develop all aspects of this re-certification process and periodically audit its effectiveness.

Lastly, the Office of Mental Health should, within the eligibility process, devise a method to allow individuals who have moved from population II to population III to be immediately recertified in population II if their condition deteriorates, thus warranting the network of services suitable for population II.

(3) Population Group III– Periodically Served Population

This population will consist of those individuals who periodically or intermittently use the public mental health system or are at risk of becoming mentally ill. Individuals in population III who ultimately meet the eligibility requirements for population II will be enrolled accordingly.

(b) Client Mobility

A process should be established by the Office of Mental Health to deal with clients in populations II and III who move from one mental health region to another. Their relocation should not result in a situation where they are lost to the system, even for a short time.

RECOMMENDATION FOUR

Funding of services provided in the public mental health system should be simplified and allocated locally in a manner that most effectively addresses the needs of the mentally ill population.

The local management should be, in the broadest sense, responsible for the delivery of mental health services to all persons residing in the region. Table C illustrates the proposed financial relationships between the local management and populations I, II and III.

Table C

Population Group	Local Management Financial Responsibility
I. Current Long-Term Care	(None)
II. System Dependent	All mental health services
III. Periodically Served	Portions of all mental health services

(a) Financing of Populations

(1) Population I– Current Long-Term Care Population

The long-term care population should continue to be financially supported in state psychiatric centers and family care programs by the present combination of state, Medicare and Medicaid funding. The Office of Mental Health will have financial responsibility for this population. The state should supply all services for the duration of each patient's stay. Due to the extended and continuous long-term nature of the care utilized by this population, financial responsibility by the local management is not warranted. Local managements should be responsible to see that all population I clients are regularly evaluated by the facility for possible transfer to the community. Local managements should also cooperate with state facility staff in the development of treatment and discharge plans. Local managements should be reimbursed for this specific function via grants from the state.

The local management, after consultation with the facility, must certify a population I client for discharge to the community. State financial support to the local management for long-term care patients leaving state care would begin immediately upon discharge, as patients then become members of population II. *The dollars will, therefore, immediately follow the patient into the community.* It is hoped that movement of population I clients to community residential settings will not result in significant additional systemwide costs. Any realized reductions in state psychiatric center expenditures associated with the discharge or death of population I clients should be accounted for in the state executive budget. State psychiatric center costs are both fixed and variable and the Select Commission would urge that, to the greatest extent possible, the variable costs follow the patient to the community.

(2) Population II– System Dependent Population

The system dependent population is markedly disabled by reason of mental illness and is the population that the Select Commission intends to be most affected by its recommendations. Therefore, the local management in each mental health region should be held *strictly accountable* for each individual in this population. The following financial recommendations have been developed to provide local managements with a means to carry out this responsibility. In general, the objectives of these recommendations are to:

- Assure the provision of a full range of public mental health services to all individuals in population II;
- Finance all such services at 100 percent state cost (less federal and other third party reimbursement);
- Assure the provision of mental health services to persons residing in nursing homes (SNF) and health related facilities (HRF);
- Expand the community-based mental health service system; and,
- Allow for the provision of care to the system dependent population in the most appropriate settings.

To facilitate these objectives, local managements, as they become established throughout the state, should be financed principally through two streams of funding to serve the system dependent mentally ill. The first is an annual prospective appropriation from the Office of Mental Health to insure that public mental health care and housing is provided to all individuals in population II (excluding SNF and HRF residents). The second appropriation, also from the Office of Mental Health, is to insure that SNF and HRF patients in each mental health region receive the necessary level of mental health services. A brief discussion of these financing mechanisms follows.

Capitation Financing

The first and far larger of the two allocations will be computed as the product of the total number of system dependent mentally ill in the region (who may be residing in either state psychiatric centers or in the community) and the estimated average annual cost required to sustain each of these individuals (capitation rate). The average annual cost per client will be established by the Office of Mental Health prior to each year and adjusted for each mental health region with input from the respective local management.

As an incentive for local managements to expand current community-based services and develop new ones, their prospective budgets should be supplemented annually by a three to five percent increment. Each local management should receive the same percentage supplement. The use of these funds should be fully discussed in the annual plan submitted to the Office of Mental Health.

The prospective budget should be used to support all mental health services and housing applicable to the system dependent population. Local managements will contract with local providers of services (including state psychiatric centers) and reimburse providers on a rate per visit or per diem basis. State psychiatric center per diem rates should be established by the Office of Mental Health and revised annually. The prospective budgets will be revised annually by a cost-of-living adjustment or a trend factor determined by a newly proposed panel on mental health economics. Annual revisions will account for changes in inflation, enrollment, persistent increases in population II patients at state psychiatric centers, increases in per diem and per visit rates, and other uncontrollable cost items identified by the panel.

The local managements should be responsible for collecting federal and other third party revenues, as this income will be included as part of the annual prospective budget.

Local managements should be provided with incentives to accept responsibility for population I patients who clinically and otherwise are found to be eligible for community placement. Therefore, to enhance community placements of population I patients, local managements will immediately receive capitation funding for each population I patient upon discharge. In addition, should re-admission to a state psychiatric center occur, local managements will incur financial liability only for the initial 180 days of care. After that time, financial responsibility for the patient will be assumed by the state.

If the local management satisfies the contractual performance standards set forth by the Office of Mental Health, it will be allowed to utilize any savings that may accrue. Proposed use of savings should be documented in the annual plan and approved by the Office of Mental Health. Local managements should be "at-risk" for all overexpenditures of the annual prospective budget. The state should participate in reducing or eliminating the annual deficit where the cause of the overexpenditure is justified and meets the criteria set forth in advance jointly by the state and local managements.

The Select Commission concludes that the capitation model holds a great potential for success. Nonetheless, it recommends that the efficacy of capitation financing be demonstrated prior to expanding this model statewide. Such pilot demonstrations should be conducted by the Office of Mental Health in at least three regions of the state, one rural, one upstate urban and one of the boroughs of New York City. Individuals should become eligible for these pilot demonstrations based on the recommended eligibility process addressed in recommendation three.

Until such time as capitation financing is implemented on a statewide basis, several immediate or interim steps are recommended as follows:

- The Office of Mental Health should develop and implement a statewide client management and tracking system that fully protects the confidentiality of patient records.
- The Office of Mental Health should investigate and ascertain the average annual mental health and housing costs by county for clients in population II.
- The Office of Mental Health should place all state psychiatric centers on the uniform budget reporting system.
- The Office of Mental Health should consolidate funding for the community support system program (CSS) and the chapter 620-621 programs into one financial stream to immediately ease much of the financial complexity inherent in the public mental health system today. Consolidated funding should be utilized until capitation becomes a reality.
- The executive and legislative branches of government should transfer responsibility for all mental health funds in the Medicaid budget, including those for housing of the mentally ill, from the Department of Social Services to the Office of Mental Health.
- The Office of Mental Health, using a panel of clinical experts, should establish eligibility definitions for populations I and II.
- The Office of Mental Health should begin to establish policies and procedures to allow for the efficient phasing-in of capitation financing in all mental health regions, should the capitation pilot demonstrations merit full statewide implementation.
- The Office of Mental Health should establish a financial grant or contract mechanism to fund the staff of each local management. Staffing levels should be equitable and vary among local managements based on size of population served and other variables, as deemed appropriate. Staffing standards should be established by the Office of Mental Health and approved by the Mental Health Services Council. Appropriate levels of local management staffing are essential to the success of this form of management.
- The Office of Mental Health should initiate a study for the purpose of identifying the impact of reimbursement based on diagnostic related groups (D.R.G.s) on short stay acute hospitals.

SNF and HRF Population Financing

The second allocation to local managements for system dependent clients should be used to supplement the mental health services now provided to SNF and HRF patients. This allocation should not be used to support services presently provided in each SNF or HRF. It should be based on a formula which provides either $2 per day (1984 dollars) for each SNF and HRF occupant who would otherwise be eligible for population II,

or $1 per day for all SNF and HRF occupants—whichever represents the greater amount.

Resources for State Psychiatric Centers—Even with the proposed expansion of community-based services, the need for state psychiatric centers to provide care in the future for population I and II clients will continue, although the percentages of population II clients in state psychiatric centers will increase over a period of time. Further, it is recognized that the needs of those requiring care in the state-operated system will change. The increasing numbers of young aggressive males, older frail geriatric patients and forensic patients are but three of the demographic pressures that state psychiatric centers must contend with.

State psychiatric centers must have the support necessary to assure that the care they provide meets quality standards. It is clear that, to date, staffing has not kept up with the demands placed on these state institutions. The services provided to population I and II patients at psychiatric centers and the quality of the living environment found in these institutions must be substantially improved.

Accordingly, the state should give priority attention to the attainment of adequate staffing levels and a more appropriate staffing mix at each facility. The level of staffing should not be permitted to fall below standards of adequacy as set forth by the Joint Commission on Accreditation of Hospitals. The staffing mix should guarantee the quality of medical, nursing, clinical and rehabilitation staffing necessary to assure that effective treatment and rehabilitation programs are uniformly available to all state psychiatric center patients.

(3) Population III–
Periodically Served Population

(a) This population group, composed of those individuals requiring periodic or intermittent mental health care, should also be the financial responsibility of local managements. The provision of necessary mental health services including, but not limited to, crisis outreach, clinic, day treatment, partial hospitalization, education, prevention services and targeted case management services, should be financed through formula-based per capita grants to local managements. This financial mechanism is designed to replace the current deficit financing practice of state aid to localities. In addition, per capita financing should supplement revenue from other public and private sources (e.g., Medicaid) for this population.

(b) Per capita funding should assure that the aggregate statewide funding level for the periodically served population be equal to or greater than its present share of the local assistance budget (trended for inflation).

(c) The per capita grant formula approach should be established in state law to assure that funding levels change with inflation and changing population dynamics.

(d) The development of a formula approach and any changes to the approach should be approved by the proposed panel on mental health economics.

(e) To build toward a more equitably distributed service system throughout the state and to minimize the cost to the state to achieve such equity, it is essential that the per capita grant program include a mandatory local match comprised of a local tax levy and/or voluntary contribution. This match should be equal to a fixed percentage of available state per capita aid.

(f) The disparity in current state aid per capita among all of New York State's counties will require several years of modification to attain reasonable statewide equity. In no case will the local share in any county be increased to maintain its current service level, adjusted for inflation. All counties should be held harmless with respect to future increases in state per capita grant appropriations to account for inflation, and to narrow the per capita aid differentials among counties.

(g) The special fiscal considerations granted to small rural counties with a population of less than 200,000 in Section 41.18 of the Mental Hygiene Law should be incorporated into the per capita grant allocation process in order to account for differences in economy of scale.

(h) The formula for allocating state per capita grant aid should be based on needs assessment methodologies, and at risk and minority populations should receive a proportionately higher level of funding.

(i) The Select Commission recommends that local managements be required to devote at least three percent of their gross per capita aid program (state and local share) to prevention, consultation and education activities.

RECOMMENDATION FIVE

The state should provide the necessary fiscal incentives and establish a capitalization assistance program for the acquisition, renovation and construction of facilities to expand special needs housing and community-based services for the mentally ill.

One of the major impediments to the development of special needs residences and day services for the mentally ill is the difficulty in securing financing for the acquisition, renovation or new construction of necessary facilities for such programming. The Select Commission finds that there is difficulty in securing program development financing and recommends the establishment of a state financed capitalization program. This program should be accessible to local managements and providers which have submitted applications to the state for day and continuing treatment, psycho-social

clubs, residential treatment facilities, community residences, domiciliary care facility programs, etc.

The capitalization assistance program will consist of several funding mechanisms, including bond issues, a mortgage guarantee pool, revolving loan funds and direct grants. The administrative agent for such a pool may be the Office of Mental Health, the New York State Housing Finance Agency, the State of New York Mortgage Agency, the New York State Dormitory Authority, the Urban Development Corporation, or whichever existing state agency or authority the executive and legislative branches may designate. It is hoped that this finite pool of state funds will leverage the greatest possible private financial participation in the development of community-based mental health programs.

To assure the rational distribution of limited capital funds, the state should develop and implement an expanded certificate of need process for *all* publicly approved mental health programs and residences. It is not expected that every new program or residence (particularly those sponsored by institutions with access to private financing) will depend upon this capitalization program in order to proceed with its project.

However, the state should take several actions which will maximize the providers' access to private capital financing. These include the establishment of a rate methodology to reimburse providers based on reasonable costs, the timely processing and approval of such rates, expeditious processing of claims, and closing the critical time lag for new programs dependent on Medicaid reimbursement to receive their official authorization as Medicaid providers.

The Select Commission's advocacy of a capitalization program does not imply in any way an expression or belief that the state is responsible for the provision of housing in the community for all mentally ill persons, nor any opinion on pending litigation in this matter. This program, however, would begin to address the supportive housing needs of some mentally ill persons in New York. Amortization and debt service will necessarily be the providers' financial responsibility within the funds allocated from the various funding streams received (capitation, per capita grants and other public/private funds). Evaluation of applications for capitalization assistance will give priority to those projects which (a) reduce inappropriate utilization of psychiatric inpatient beds, and (b) meet the housing needs of the undomiciled mentally ill.

RECOMMENDATION SIX

The State Departments of Health and Insurance and the Office of Mental Health, augmented by multidisciplinary input from the public and private sectors, should investigate appropriate mental health insurance benefit packages and ascertain the feasibility of expanding private mental health insurance coverage.

The fact that short-term treatment for nervous and emotional disorders may have a lasting effect upon a person's health and well-being has been well documented, as has the fact that such treatment may lessen inappropriate utilization of other, often expensive mental health care benefits. Modern advances in pharmacology, psychotherapy and community care, moreover, have reversed the long-term nature of mental illness care and have brought mental health treatment and hospital lengths of stay on a par with those for physical illness. In 1977, the New York State legislature recognized the fact that expenses incurred for such diagnosis and treatment may pose an undue financial burden upon the uninsured and, therefore, required all insurance companies, which issue group health insurance policies in New York, to make available basic minimum benefits for the diagnosis and treatment of mental, nervous or emotional disorders or ailments.

Yet, unlike the general health care industry, where third party payments from private and public health insurance are widely available to cover a substantial portion of the cost, the mental health industry continues to receive limited third party reimbursement, especially for outpatient care.

In recognition of this fact, and also to help prevent population III individuals from clinically deteriorating to the point of requiring the level of care associated with population II, the Select Commission urges the Governor to direct the State Departments of Health and Insurance and the Office of Mental Health to immediately create a high level ad hoc study group. Its purpose will be to establish an appropriate benefit package for mental health services and investigate the implications of broadening Section 174-A of the Insurance Law by including mental health care as a required benefit of all private "full benefit" insurance packages. This study group should seek interdisciplinary advice from business, third party insurers, providers and the public prior to reporting its findings and recommendations.

3. MANAGEMENT

RECOMMENDATION SEVEN

The public mental health system should be administered in each local mental health region by a local management sponsored by the state, local government or a quasi-public organization.

(a) The State of New York should be divided into several mental health regions. These regions should encompass the geographic boundaries of a county, or two or more contiguous counties.

(b) Each mental health region should be directed by a single local management with administrative responsibility and accountability for all residents who are men-

tally ill or at risk for mental illness. For those patients in population I, the local management responsibilities are limited to assuring the provision of community-based services and housing as they are found to be capable of returning to the community.

(c) Local managements may be sponsored by any one of the following:

- **County government, a consortium of county governments or New York City government.** The Select Commission envisions the creation of distinct governmental units that have an exclusive mission of managing the local mental health system. Present local government departments of mental health would continue to function as providers of service under contract to the local management. Waivers of this provision should be made available by the Office of Mental Health where appropriate justification exists.
- **The state.** Consistent with the above, where the state becomes the local management, the specific organizational entity entrusted with this responsibility should not be a component of a service delivery agency. Therefore, the local management should, of necessity, be external to all service delivery components of the Office of Mental Health.
- **A quasi-public or not-for-profit corporation.** A local management of this type should constitute a policy board of directors comprised of representatives from the state, local government, voluntary sector and community representatives to include patient advocates, community-based providers and parents.

(d) The diversity of the state, as reflected in its different service configurations, population needs, providers and financial resources, requires different management approaches to address specialized regional needs. It is expected that all state, local government and voluntary providers will continue to render services under contract to the local management.

The Office of Mental Health will designate the geographic boundaries for each mental health region, and the sponsorship or type of local management, following consultation with local governments and providers. Each local government, after consultation with providers, consumers and advocates, should present its choice of local management to the Office of Mental Health for approval. Prior to such designations, the Office of Mental Health, with assistance provided by an ad hoc task force composed of representatives of the Mental Health Services Council, local government, voluntary providers, consumers, parents of mentally ill children and other mental health advocates, should establish a series of objective criteria and standards to be used for the selection of local managements. The criteria and standards should require that each local management establish and maintain the following:

- Accountability for service to populations II and III
- Demonstrated contracting capability
- A corporate plan and structure
- Written policies and procedures
- Demonstrated competency in the administration and fiscal management of public mental health services
- A board structure
- Capability to develop and carry out an integrated mental health services planning process
- Capability to assume financial responsibility and risk for population II clients
- Capability to assure the provision of case management services
- A willingness to carry out the policies, rules and regulations of the state
- A conflict resolution process
- Staff recruitment and financing practices for minorities
- A willingness and capability to integrate a wide variety of state and local agencies.

Additional criteria and standards may be developed as necessary.

Local managements should not be direct providers of service. As such, the Select Commission wishes to remove any doubt with respect to the eligibility of state and local governments to become local managements in one or more mental health regions. The Select Commission's intent is to remove the local management, to the greatest degree possible, from any potential conflict of interest. It is envisioned that the local management function within state and local government will be organizationally separate from all direct service delivery functions. Waivers should be available where this separation is impossible or counterproductive.

Localities (local government or other non-provider groups that may come forward) should be encouraged through a request for proposal to submit proposals to the Office of Mental Health. Proposals should specify the sponsorship or type of the local management as well as the suggested geographic boundaries for the respective mental health region. The Office of Mental Health should use the above criteria as a basis for making designations. The Mental Health Services Council should be consulted and should make recommendations to the Office of Mental Health on each designation. In addition, it should also review and comment on all appeals from localities whose proposals were disapproved by the Office of Mental Health.

In regions where proposals are deemed by the state to be inadequate or where there are no proposals submitted to the Office of Mental Health, the sponsorship of the local management should be assumed by the state. The local management so designated should insure a catchment area of sufficient size, an array of services (or plans for such services) capable of meeting the unique needs of that area, and a rational integration of existing providers.

(e) For each local management, an advisory board will be constituted with representatives from local mental and generic health providers, local and state government, short-stay acute hospitals, former patients, special population groups, including minorities, children and youth, etc., parents or relatives of mentally disabled persons and civic leaders with expertise in mental health services.

- If the local management is a county, a group of coun-

ties or New York City, local government may elect to empower the advisory board as a policy body. Many existing community service boards would serve this purpose well.

- If the local management is a not-for-profit corporation or a quasi-public authority, the board will, of necessity, be a policy body. The corporation or authority may choose, in addition, to appoint such advisory group(s) as it deems necessary. The membership and functions of the advisory board should be described in the enabling legislation. Such a local management will need to hire its own staff and be independent of any provider interest.

(f) Each local management will enter into a legal agreement with the Office of Mental Health and be held fully accountable for a wide range of activities. The contract should also specify the role and responsibilities of the state. The prime responsibility of the local management would be the assurance that a comprehensive array of clinically appropriate services is provided to or planned for all population II and III clients. The assurance that a system of case management is in place, including outreach case management, aftercare services and advocacy in the community, will be firmly fixed as a critical responsibility of each local management. The essence here is one of the local management having primary responsibility for patient accountability.

A local management should have the capability to develop, in a reasonable amount of time, administrative expertise, fiscal competency, county and/or city government confidence and good community relations—all of which must accompany any efforts to insure the provision of adequate care for those most in need.

Local managements, with input from local governmental units where applicable, will submit to the Office of Mental Health annual plans outlining how they will meet their mandated responsibilities to assure continuity of care, case management, service delivery, and to directly provide for accessibility for all eligible clients, as well as for coordination among local public mental health providers and generic health, education, social service, mental hygiene, aging and housing programs. These plans should also specifically address the needs of special population groups (e.g., children and youth) and document how state psychiatric centers will be affected during the forthcoming year.

An automated data base for client management and tracking should be developed by the Office of Mental Health and utilized by each local management to carefully monitor and review how population II and III patients utilize services. This data base should provide assurance that patient confidentiality is maintained. In concert with the state, local managements will utilize needs assessment methodologies to identify priority programs and services to fill critical gaps in the system.

Local managements will be held strictly accountable to the state for the budgeting and fiscal management of all income received from the state and other sources, and disbursements to providers through capitation and per capita formulae and other consolidated funding mechanisms. All budgets and planning documents will be approved by the policy-making board of the local management, as well as discussed in advance of submission with the appropriate advisory board(s) constituted to afford the greatest participation of consumers and their families. Together with the state, the local managements will set as a priority the stimulation and development of new community-based services and special needs housing for those found most in need.

Local managements will carry out all state policies and adhere to state rules, regulations and standards. In cooperation with state initiatives, they will insure coordination between generic health, education, aging, social service, other mental hygiene and housing agencies and public mental health services at the local level. They will conduct education and promotion efforts to alert the public to mental health issues and ease the acceptance of expanded community services, and apply a fixed percentage of the per capita grant to develop and carry out mental health prevention programs.

The local managements, in coordination with the Office of Mental Health, must provide for two levels of *conflict resolution/arbitration.* The first, concerning patient specific conflicts (e.g., dissatisfaction with case disposition) within a mental health region, should be dealt with expeditiously by each local management using a conflict resolution panel to be composed of public and private sector representatives. Where resolution cannot be reached, the matter should be elevated to a subcommittee of the Mental Health Services Council. It is essential that all patient specific conflicts be expedited without delay.

The second level of conflict resolution relates to areas of discretionary decision-making at either the state or local level. Such decision-making is often desirable in order to insure organizational flexibility in responding to a variety of concerns. Where decisions have a questionable or negative impact on one or more local managements or on the state, the same subcommittee of the Mental Health Services Council should be called upon to mediate or review the issues and make a written recommendation to the Office of Mental Health. Fair representation on the council should be afforded to local managements to insure an objective process of conflict resolution.

Local managements will, following state policy, insure that sufficient training and incentives are provided to encourage the recruitment of personnel sensitive to the cultural and ethnic differences found among their clients.

Lastly, all local managements should convene jointly, at least semi-annually, to participate in information sharing and problem identification/resolution sessions. It will be incumbent on the Office of Mental Health to coordinate and facilitate these programs.

(g) Each local management will be funded and staffed appropriately to assure that the responsibilities described in "f" are carried out effectively.

(h) Local accountability is the central theme on which the concept of local management is built. The formal

contract between the Office of Mental Health and each local management should be explicit in this regard. It should specify the essential activities required of each local management. It should also state the actions that may be taken by the state should these requirements not be met. From the outset, the local management must have a clear vision of its mission, adequate financial support to carry out the mission and an understanding as to the sanctions that may be imposed by the state for failure to perform satisfactorily.

(i) **Mental Hygiene Management**–The recommendations of the Select Commission, especially those relating to management, were not developed to address the entire realm of mental hygiene disabilities. The charge to the Select Commission was very specific, confining its activities to the mental health system. Where possible, the recommendations call for enhanced coordination among all of the mental hygiene disability agencies, at both the state and local levels. The Select Commisson, from the onset, agreed not to extend its review beyond the charge and in so doing, wishes not to further fragment the local system of management. Therefore, a more thorough review of the implications of the Select Commission's report on the role of local governments, with respect to mental hygiene management, should be directed by the Governor.

RECOMMENDATION EIGHT

The Office of Mental Health should be reorganized and made responsible to provide direction over the entire statewide mental health system.

(a) The Select Commission is in full agreement that the Office of Mental Health should be reorganized into discrete operational units that separate and highlight the agency's three principal functions: (1) management and provision of state psychiatric center care; (2) stimulation of a comprehensive and properly balanced care system in the community; and (3) regulation, certification, funding and direction of the public mental health system. This organization pattern provides a structure within the agency to give priority direction to the continued growth of a properly balanced public mental health system.

However, beyond this recommendation to reorganize the Office of Mental Health, there was a very strong voice throughout the Select Commission that endorsed the concept of removing state psychiatric center service delivery functions from the Office of Mental Health. This recommendation, if endorsed by the Select Commission, would have proposed reassigning the functions of state psychiatric center operations to another state agency or to a public benefit corporation. Other alternatives may also be feasible.

(b) **Administrative and Fiscal Responsibilities of the Office of Mental Health**–The Office of Mental Health should exercise the fullest authority and oversight over the entire public mental health system, consistent with the authority provided for in the Mental Hygiene Law. Its paramount responsibility will be one of being accountable for a comprehensive, accessible and well-coordinated system of mental health services for those citizens of the state who rely on the public system for care. Although some statutes and many regulations may need to be amended or rewritten completely to reflect the Select Commission's recommendations, it is intended that the Office of Mental Health be vested with the necessary executive authority and resources to perform its vital leadership role.

In moving toward a statewide population-based planning process for allocating resources, the Office of Mental Health will be expected to design, execute and refine needs assessment methodologies either directly or by contract with a university skilled in this technique. Needs assessment methodologies should insure equity and accessibility for those most in need within target populations, and provide incentives for expansion of community-based services. The Office of Mental Health should develop and implement service and outcome standards for all programs, regardless of auspice. Implicit in this process will be the initial task of defining the three population groups described in this report, utilizing a panel of clinical experts to be chosen with public and private sector input.

The Office of Mental Health should be charged with the selection and regulation of all local managements and should encourage the maximum possible local input from all interested parties in deciding upon the geographic configuration and type of each local management. Where county government or quasi-public/nonprofit corporation-administered local managements are deemed by the state to be ineffective or incapable of meeting their contractual obligations and fiscal responsibilities, the Office of Mental Health should have the authority, vested in statute, to terminate that local management and either directly assume its responsibilities as a state-administered local management or substitute another sponsor.

The Office of Mental Health should not hesitate to designate local government and quasi-public/not-for-profit corporation local managements as appropriate to a region. It is expected that the Office of Mental Health will provide technical assistance to localities for the purpose of ascertaining the advantages and/or disadvantages of assuming the role of a local management. The Office of Mental Health should assure that in each local management, proper responsibility is firmly fixed for case management and service provision for all three populations. To assist the local management in this respect, the Office of Mental Health should develop a computerized patient management and tracking system for use in each mental health region.

The state will provide fiscal allocations to local managements as described elsewhere in this report in the form of consolidated funding mechanisms, to ultimately include capitation for population II and per capita grants

for population III. Minimum staffing levels, rate-setting and other budgetary considerations will be incorporated by the Office of Mental Health into a comprehensive budget submission to the Governor that reflects the implementation of the new consolidated funding streams in cooperation with the local managements.

The Office of Mental Health will inspect, certify and regulate all public mental health providers and local managements to insure their conformance with all relevant statutes and regulations. A strong quality assurance monitoring process must be built into the system that promotes clinical excellence. The coordination of the various local managements will necessitate a clearly enunciated statement of policy goals for the entire system, as reflected in an enhanced planning process. All regional plans submitted for review to the Office of Mental Health must provide for the accessibility of services to at-risk and minority populations and promote affirmative action in all personnel practices. Together with the local managements, the state should stimulate the creation of new community-based care providers and special needs housing.

The Office of Mental Health will represent the interests of the entire public mental health system before the state executive and legislative branches of government, as well as the appropriate federal agencies. The coordination of policies and programs with other state agencies—particularly the Departments of Health, Education, and Social Services, the Office for the Aging, the Office of Mental Retardation and Developmental Disabilities, the Division for Youth and the Divisions of Housing, Substance Abuse Services, Alcoholism and Alcohol Abuse, and the Council on Children and Families—will be critical in insuring that the generic health, human service and housing needs of the defined populations are satisfactorily addressed. The responsibility for stimulating and enhancing interdepartmental coordination should continue to be vested with the Council for Mental Hygiene Planning.

The Office of Mental Health should expand the numbers and kinds of demonstration programs targeted to fill service gaps for children, the multiply-disabled, minorities, the aging-out adolescent population at risk of serious mental illness and the special needs of rural communities. It will continue to directly administer forensic facilities and programs as charged by state law.

The Office of Mental Health should provide sufficient training and incentives to insure the successful recruitment of personnel sensitive to cultural and ethnic differences among its clients. As described in principle fifteen, an active research and evaluation program, under state supervision, must be an integral part of any public mental health system and should be fully integrated into the planning efforts which will guide the distribution of available resources.

(c) **Relationship of local managements with state psychiatric centers and community providers**—The Office of Mental Health will continue to administer and manage directly all of its psychiatric centers for children and adults, as well as its family care programs. Referrals for admission will be made by the local managements, and discharge plans will be clinically and administratively coordinated between the psychiatric center and the respective local management. The Office of Mental Health and local managements should introduce models that promote clinical integration among state and local psychiatric facilities. The purpose of the clinical integration model is to insure that the needs of patients for a continuum of care, from acute to intermediate to long-term care, are met regardless of provider auspice.

The state psychiatric centers and the local managements should mutually agree on all admissions and patients may not be discharged to the community care system without approval by the respective local management. The function of clinical coordination is essential to the development of a successful relationship. Should a conflict arise between a local management and a state psychiatric center relative to the disposition of a patient, the conflict resolution process proposed in recommendation seven, subsection (f), should be activated. During the patient's stay in the psychiatric center, care will be provided by psychiatric center staff according to its policies.

The Select Commission recognizes that close coordination between all community-based providers and the local management will require ongoing cooperation. Aftercare planning and actual service delivery should be jointly executed by both the provider and the local management, with a careful assignment of roles and responsibilities mutually agreed upon and clarified by contract. It will be incumbent on all parties involved in this system to ensure that it functions efficiently and humanely, to be clear about the fixed responsibility for case management and clinical judgment, and to make every effort to avoid the gaps in service delivery that now characterize much of the current system.

(d) **Future role of state psychiatric centers**—The Select Commission believes in the continued viability of state psychiatric centers. Several expert studies reflect a varied opinion as to the number of present psychiatric center patients that would benefit from community placement. The range is from a low of 2,000 to a high of about 9,000. The Select Commission would agree, at least, with the low estimate and endorses the development of new community-based services and housing to accommodate the transfer of these patients to the community. This should not imply that more than this number could not be transferred to the community system of care as it expands.

Several variables make psychiatric center utilization estimations difficult. For instance, future demand on state psychiatric centers will materialize as a result of increasing young chronic and elderly populations. As the age 18-45 population increases and new cases are found requiring long-term inpatient care (many of which are very hard to manage), the psychiatric center system of care will be asked to accommodate this demand for services. Such will also be the case for the rapidly expanding elderly population.

In addition, state psychiatric centers in partnership

with community agencies will be required to provide long-term protective care or asylum care to a significant population statewide. This role is a necessary one and will likely remain unchanged.

Therefore, until a cure for schizophrenia is discovered that will have an impact on the level of care provided by state psychiatric centers, the Select Commission foresees little or no substantial decrease in overall utilization. Unless and until a major augmentation of community-based care is realized, reliance on long-term institutional settings will continue.

(e) Miscellaneous

1. **Implementation Process**—The Select Commission believes that the recommendations contained in this report will "charter a course" for needed changes in the public mental health system. To provide assurance that the various options for implementation are evaluated and the barriers to implementation assessed, the Select Commission recommends that the Governor establish an implementation panel. The panel should be composed of individuals who represent the major constituent groups in New York's public mental health system. In lieu of creating a new body, the Select Commission would endorse the assignment of this responsibility to the Mental Health Services Council.
2. **Report of the Subcommittee on the New York City Psychiatric Bed Crisis (Appendix F).**

   This Select Commission report was submitted to the Governor in December, 1983. At this time, the Select Commission wishes to congratulate the Office of Mental Health and the New York City Department of Mental Health, Mental Retardation and Alcoholism Services on their efforts to implement the recommendations contained in the report. The Select Commission further recommends that the New York State and New York City governments fully implement each of this report's recommendations, without delay.

RECOMMENDATION NINE

The public employee work force should be guaranteed job continuity and provided with opportunities for employment in the community-based system of mental health care.

It is imperative that the Office of Mental Health and the Governor's Office take all necessary actions to insure job continuity for state psychiatric center employees and enable employees, who may ultimately be transferred from state psychiatric center employment to the community care system, to make such transitions with adequate training. The state should also consider the broader implications of proposed systemwide changes for local government and voluntary sector employees. The potential impact on the job continuity of all mental health workers should be carefully weighed in arriving at policy decisions. In addition, should local government or private sector mental health employees be dislocated, the state should give them priority with respect to recruitment into the state work force.

Several proposals have been circulated this past year which would creatively use existing state psychiatric center campuses to retrain state workers and provide community services. Two of the most noteworthy of these proposals are the WRI Proposal entitled, "An Approach to the Expansion and Enhancement of Community-Based Residential/Day Treatment Programs and Continuity of Care for Mental Health Clients," and the Rockland Psychiatric Center-Nathan S. Kline Institute, Rockland Children's Psychiatric Center Campus Proposal. These proposals, and others, may lead to expansions in the state work force at the community-based level. Their impact, and the impact on other proposals that may emerge, should be incorporated into the local management planning process. The Office of Mental Health should test the efficacy of these proposals by authorizing and funding demonstration projects.

4. PLANNING

RECOMMENDATION TEN

It is essential that the present process of mental health services planning be reconstructed and expressed as a population and need-based planning process that assures coordination between the state and each local management.

(a) A unit in the Office of Mental Health should be assigned the exclusive responsibility of designing and administering systems planning policies and should be adequately funded to carry out this function. The Mental Health Services Council should be vested with the responsibility to provide advice to the Office of Mental Health on this process. The Mental Health Services Council, in providing that advice, will convene a special state-level planning task force and charge it with the aim of developing a statewide uniform planning format/framework to be used as a base for the development of long range plans. As local managements are established and vested with the responsibility for developing a mental health plan, each region should have an established planning group broadly representative of both consumers and providers.

(b) The systems planning policies of the Office of Mental Health should be designed to accomplish the policy goals and objectives of the agency. In so doing, they should encompass two realms of forecasting and decision-making:

(1) **Strategic Systems Planning**

This process will result in the description of a fu-

ture model system of services with availability expressed in population-based standards for local areas and regions. Such standards should address the needs of special population groups including children and youth, the elderly, the young chronics, the homeless and minorities. The plan would also assign mission expectations for all public mental health system providers, including state government, local government, voluntary nonprofit and private practice professionals, as well as those from other service systems (education, social services, etc.).

(2) **Administrative Planning for Office of Mental Health Programs and Facilities**
This process will specify the development of program and facility mission statements. It will also allocate state funds in a manner consistent with the strategic system plan, and specify short- and long-term goals for the psychiatric center system. Such a plan would detail annual activities to be undertaken by the Office of Mental Health to achieve the goals described therein. The Office of Mental Health's Division of Planning and Evaluation should review the agency's annual budget request prior to submission to the Division of the Budget.

(c) Both mental health planning efforts should have activities designed into their preparation and review processes to involve local managements, local governmental units, the eight local health systems agencies and the designated state health planning and development agency. The present structure of planning at the local level, one incorporating local governmental units and other concerned groups, should not be dismantled. Rather, any revision to the planning process should build upon this system.

Since most mental illness is managed within the traditional health system, it is vital that planning efforts bridge the generic and specialized mental health sectors. In addition, those segments of the local plan that deal with special populations (e.g., children and youth, adults, the elderly, the homeless, minorities, etc.) should be closely integrated with the formal planning processes of other agencies serving the region and, in fact, developed in consultation with such agencies. The plan should also contain specific components addressing family support services, the multiply disabled and the dually diagnosed patients. In addition, it should identify resources within the region that can enhance parental abilities to care for mentally ill children and reduce family stress.

(d) The Office of Mental Health, with the assistance of local governments, the eight local health systems agencies and the designated state health planning and development agency, should develop needs assessment methodologies for both inpatient and community-based public mental health services. Contracts with universities may also be considered for this purpose. Needs assessment methodologies should be constructed to account for reasonable substitution effects among several sites of service to avoid duplication and built-in inefficiency.

(e) Objective needs assessment methodologies and other population-based services need indicators should be employed as guidelines for future decision-making in certificate of need issuance and licensure, and in funding allocations recognizing the diversity of needs among local service areas.

(f) Where possible, the geographic planning areas of the eight health systems agencies should be coterminous with mental health regions. In no instance should a local management have to coordinate its planning efforts with more than one local health systems agency.

5. RESEARCH AND EVALUATION

RECOMMENDATION ELEVEN

The Office of Mental Health, utilizing its renowned research institutes and other resources, should promote research and evaluation efforts as a fundamental priority.

New York should sponsor and conduct continuing basic and applied research into the causes and treatment of mental illness, and should regularly and systematically evaluate both state and community mental health programs with respect to performance standards, quality standards, and regulations.

For these purposes, the Office of Mental Health should:

(a) Determine the most effective treatment course for mentally ill patients after their acute symptomatology has been stabilized.

(b) Analyze and recommend effective alternatives to hospitalization for the treatment of acute and non-acute mental illness.

(c) Continue epidemiological studies to develop further data on the familial and societal factors of the environment, genetic factors, nutrition, pregnancy and birth complications, environmental pollutants and slow viruses apt to cause or exacerbate mental illness, particularly as these involve children.

(d) Identify those social and environmental factors that most significantly contribute to the development of dementias, both in community and institutional settings.

(e) Continue research into the pathophysiological processes related to the development of mental disorders and continue research to both study the effects on prolonged use of psychotropic medications and to discover more effective therapeutic medications that are safer and have fewer side effects, especially for those suffering from schizophrenia and manic depression.

(f) Act as a clearinghouse for the review, examination and compilation of existing research to provide mental health providers, clinicians and the public with the most pertinent current information available.

(g) Promote uniform data collection regarding charac-

teristics, size, service needs and utilization patterns of the mentally ill.

(h) Establish a provider evaluation process that applies a range of qualitative and quantitative measurements to evaluate program and provider effectiveness.

(i) Initiate research strategies designed to identify a match between the appropriate service provider and the patient. Such strategies should focus on socio-economic status, culture, race and diagnoses.

The Office of Mental Health should provide funding for those programs and services that, as a result of research, are found to be efficacious. It should also apply its research expertise to the study of appropriate systemwide coordinative and management techniques.

6 Implementation Strategy

THE PROPOSED SYSTEMWIDE CHANGES recommended in chapter IV are intended to modify and significantly improve the management, financing and delivery of public mental health services in New York. The Select Commission believes that to successfully implement and carry out the recommended changes, two critical factors are essential. First, the process of change must be *deliberate and incremental.* A long-term incremental strategy, in lieu of one that is abrupt and perhaps disruptive, will minimize the stress on providers and patients alike. Second, to insure the likelihood for success, several critical actions must initially be undertaken to create the desired momentum. Ultimately, the behavioral and structural changes recommended in this report should be reflected in a more effective and humane system of mental health care.

The actions that must successfully be undertaken during the year following acceptance of this report by the Governor are the basis of this proposed implementation strategy. This strategy has been developed to provide the executive and legislative branches of state government with a blueprint to begin setting the overall recommendations into motion. The success of each of the following actions will directly affect the ultimate success of the entire plan.

1. Legislative Action

During the first year following acceptance of the Select Commission's report by the Governor, legislation should be drafted, submitted and approved to establish a time schedule for implementation of the report's recommendations relating to local management. A period of 24 months should be specified for localities to submit proposals to the Office of Mental Health suggesting geographic boundaries for mental health regions and a proposed sponsor for local management. During this period, the Office of Mental Health will review the various proposals against objective criteria and decide upon the sponsorship of local managements. Within five years, the entire state should be divided into mental health regions and a local management established for each.

2. Development of an Expanded Community-Based Care System

Beginning in the initial operational year, the state should make a strong financial commitment to develop new services in the community, especially residential programs: e.g., domiciliary care facilities, community residences and residential treatment facilities. To stimulate this expansion, the Office of Mental Health should streamline the state's regulatory and reimbursement processes and expand access to funding for capital projects through the creation of a capitalization assistance program. These mechanisms have been recommended to provide financing for the acquisition, renovation and new construction of facilities for such community-based mental health programs. Along with these additional resources, requirements for improved coordination of services should be expected. One specific mechanism would be the establishment of conflict resolution panels representing all sectors of the service system in each locality. These panels would be charged with resolving differences in patient transfers through development of admission and discharge criteria and with addressing the needs of difficult-to-place patients.

3. Financial Demonstration(s)

The recommendation addressing capitation financing for the system dependent mentally ill was developed in the absence of substantial experience. Prior to accepting the concept of capitation and expanding it throughout the state, it is recommended that its efficacy and feasibility be determined through pilot studies. The Office of Mental Health, therefore, should immediately select three regions of the state (e.g., a rural county, a large upstate urban county and a borough of New York City) and capitate the system dependent population in each.

4. Establishment of Local Managements

Statewide implementation of local managements is a process that could ultimately require several years. Many counties will require support and technical assistance from the Office of Mental Health before they can fully weigh the options of local control. Others (e.g., Monroe and Livingston Counties) may be able to adapt to a local governance model quickly. The Office of Mental Health should, therefore, move toward the establishment of local managements without delay. It is hoped that as local managements are established, the three sponsorship models—state, local government and quasi-public/not-for-profit corporation—will each be given an opportunity to function, at least on a pilot basis. The initial local managements should be closely evaluated

by the Office of Mental Health to assess the impact of each concept. Funding to staff each local management should be provided through direct grants from the Office of Mental Health upon agreement to function according to the requirements set forth by the state.

5. Operations of the Office of Mental Health

In the first operational year, the proposed reorganization of the Office of Mental Health should be implemented. The new organization, one that separates the functions of state psychiatric center management from the development of a community-based care system, should begin to address itself to the detailed recommendations of the Select Commission, namely:

(a) Development of measures to stimulate new community-based services.

(b) Creation of an integrated planning process that incorporates public and private sector input.

(c) Establishment of appropriate definitions for all three population groups.

(d) Development of needs assessment methodologies; program, process and outcome standards; a provider evaluation process, and expanded case management.

6. Review Process

The Select Commission recommends that a review process be commenced within one year after acceptance of the final report by the Governor. This process should be carried out by a review panel that would address barriers as well as evaluate options for successful implementation of the report's recommendations. A new ad hoc panel or the Mental Health Services Council should be vested with this responsibility.

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Appendix A

Goals and Objectives Summarized from the March, 1984 *Comprehensive Plan for Children and Youth Mental Health Services,* New York State Office of Mental Health.

Goals

- The development and maintenance of more adequate inpatient resources. This includes primarily the establishment and evaluation of the impact of 600 RTF beds and the consideration of additional units as needed.
- Expansion of the day treatment capacity by at least 50 percent by April 1, 1987, and further development to address documented unmet need.
- The development of comprehensive, coordinated systems of services which support children and youth living with their families or in the most clinically appropriate, minimally restrictive non-institutional settings.
- The development and evaluation of prevention and early intervention strategies for the high risk populations.

Objectives

- It is critical that families be integrally involved in the planning and implementation of a child's or adolescent's treatment. Obviously, the optimal way to accomplish this involvement is for the child to be served while living at home. When that is not possible, services must be designed to maximize the participation of either biological or surrogate parents.
- Since mentally ill children and adolescents almost always suffer a variety of functional deficits, they typically need access to a wide range of services coordinated across two or more systems. The mental health system must maintain the full cooperation of all of the systems responsible for serving the youth of the state in order to establish comprehensive systems of services for mentally ill youth.
- Different areas of the state vary substantially both in terms of the availability of services for children and youth, and in terms of the ability to coordinate the existing services. Progress toward the goals contained in this plan is similarly expected to vary. Special focus must be placed, however, on the most underserved areas and target populations.

Appendix B

Proposed Criteria for Use in Defining Population II Eligibility

Diagnosis: A patient must have one of the following Diagnostic and Statistical Manual of Mental Disorders (DSM) III diagnoses with a primary diagnosis of mental illness: the dementias, organic brain syndrome, functional psychotic disorders, or functional non-psychotic disorders that are persistent and severe in nature.

Disability: Functional disability resulting from mental illness is defined as substantial limitation in some of the following major living skills or activities of life: self-care or personal hygiene, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, interpersonal relationships and social transactions. The Office of Mental Health should establish an objective scale to determine ability on a uniform basis.

Duration of Illness: The functional disability should have been present for at least one month prior to certification in population II and should be expected to last for at least 12 months after certification. Although most persons in population II can be expected to remain in this population for extended periods, frequent re-certification of all population II clients is essential to justify continuance in this group. Such re-certification should be performed at intervals appropriate to the diagnosis and usual clinical course of the illness, but at least biennially.

Appendix C

Revisions to Select Commission Report Resulting from Public Hearing Process

THE GOVERNOR'S SELECT COMMISSION on the Future of the State-Local Mental Health System conducted eight public hearings throughout the state to allow the public a last opportunity for input. Hearings were held from September 14-24, 1984 in New York City (2), Buffalo, Rochester, Syracuse, Albany, Binghamton and Long Island (East Meadow).

During this period, Select Commission members heard testimony from approximately 200 individuals. Most of the presentations addressed the draft report of the Commission, 2,500 copies of which had been previously circulated throughout the state. As a result of this process, the Commission convened on October 1-2, 1984 to conduct an intensive review of the salient comments received at the public hearings. The following subject areas of the final report have been modified or expanded in response to public concerns. The list is not exhaustive, although it represents the more significant revisions.

1. Expanded and/or new sections on the homeless, the multiply disabled, rural populations, minorities and forensics were added to the services recommendations.
2. Recommendations dealing with client rights and patient confidentiality were added to the services, finance and management recommendations.
3. Additional references to the importance of gainful employment by the mentally ill were added to a number of the recommendations.
4. Local, public or private sector representation and input (including consumers and families of the mentally ill) were added to the recommendations addressing local management selection criteria, conflict resolution process, planning and policy boards, and the clinical panel to define population groups.
5. A new recommendation was added to demonstrate capitation financing in three areas of the state, one large urban county, a borough of New York City and a rural county.
6. Expanded and more specific wording was added to the population II eligibility and recertification processes.
7. The recommendation addressing private mental health insurance was expanded and modified.
8. Two new sections were added to the management recommendations as follows:
   - Relationship of local managements to state psychiatric centers and community providers
   - Future role of state psychiatric centers.
9. Revised and expanded recommendations to clarify how local governments become local managements; more detail on the selection process, and the need for local managements not to be direct service providers.
10. The recommendation dealing with the organization of the Office of Mental Health was expanded.
11. More thorough explanations are provided as to the Select Commission's interest in retaining the role of local governmental units and community service boards in planning and local decision-making.
12. The introduction and management recommendations were expanded noting the fact that the Select Commission's report does not address the entire mental hygiene system.
13. A recommendation was added to provide state technical assistance to counties with respect to weighing the positive and negative aspects of applying for local management designation.
14. The role of the Council for Mental Hygiene Planning was added to the management recommendations.
15. There is a new planning recommendation addressing coordination between local managements and health systems agencies and the need for coterminous planning regions.
16. A new management recommendation has been added proposing an implementation panel (perhaps the Mental Health Services Council) to evaluate the implementation of the Select Commission's recommendations.
17. A new management recommendation has been added proposing a full implementation of the Select Commission's *Report of the Subcommittee on the New York City Psychiatric Bed Crisis,* dated December, 1983. The report has been appended to the final report.
18. Fiscal projections have been added.

Appendix D

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New York State Office of Mental Health Psychiatric Center Directors

New York State Office of Mental Health Regional Directors

State Communities Aid Association, Steering Committee

Statewide Health Coordinating Council

Appendix E

Financial Projections

ALL FINANCIAL PROJECTIONS are annualized in 1984 dollars; they represent new incremental state dollars and assume full implementation of the report, unless otherwise noted.

1. **Local Management Administrative Costs**
   There should be approximately 20-25 local managements with state grant support totalling $8,500,000 annually.
2. **Client Management and Tracking System**
   Total annual cost of hardware and software for the Office of Mental Health and 20-25 local managements should be from $2.4 to $5.0 million.
3. **Capitation Financing**
   The system dependent population is estimated at approximately 100,000 individuals. The 3-5 percent add-on to the capitation rate for case funding will bear an annual cost of $105 million; the amount needed to bring the current level of services for active users up to a statewide average of $20,000 is $200 million. Within these amounts, $33 million will finance the employment of 2,500 case managers and supervisors.
4. **Per Capita Grants**
   The Select Commission recommends that per capita grant funding for population III be increased by $5 million in the initial year. In each succeeding year, these grants should continue to be increased so that by the eighth year, the increase represents a $25 million increment to the initial year base.
5. **Capitalization Program**
   In aggregate, over an eight-year period, the Select Commission recommends that, as a minimum, $100 million be made available through direct grants and an additional $105 million through a revolving loan fund to local managements and providers for the capitalization of community-based clinic, day and continuing treatment programs, psycho-social clubs and housing alternatives. Also, the Select Commission recommends the establishment of a loan guarantee program to lever, to the greatest degree possible, private construction/renovation financing. The goal is for this program to directly or indirectly finance the construction of 5,000-7,000 beds at $25,000 per bed and to begin the long process of developing an acceptable array of services in each local mental health region. The Select Commission is unable to estimate the degree to which the loan guarantee program will access financing from the private market, although it is hoped that the impact would be equal to or greater than the $205 million associated with the direct grant and revolving fund program. The above funding levels will, by no means, meet the required need for such services and housing.
6. **New State Staffing**
   (a) **State psychiatric centers**–The Select Commission requests that $40 million annually be budgeted to hire and maintain 2,000 additional employees at state psychiatric centers to enhance the quality of care.
   (b) **Office of Mental Health**–To facilitate and carry out the development of a revised planning process, needs assessment methodologies, a central management, and technical assistance expertise to implement the local management concept and the financial recommendations, the Select Commission recommends an additional $4 million annually for the Office of Mental Health to employ 160 additional staff.

APPENDIX F

The Report of the Subcommittee on the New York City Psychiatric Bed Crisis

Dick Netzer, Ph.D.
Subcommittee Chairman

December 1983

THE GOVERNOR'S SELECT COMMISSION ON THE FUTURE OF THE STATE-LOCAL MENTAL HEALTH SYSTEM

Jerome M. Goldsmith, Ed.D.
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Introduction

Governor Cuomo's Executive Order No. 24, dated September 20, 1983, established the Select Commission on the Future of the State-Local Mental Health System. The Select Commission was created to conduct a systematic review of New York's mental health system, propose steps to improve the delivery of care, establish new relationships between levels of government and recommend ways to restructure the financing of mental health services.

The Select Commission's charge included the establishment of a special Subcommittee to develop short-term recommendations to ease overcrowding of New York City's acute psychiatric inpatient services. The Governor directed the Subcommittee to evaluate the extent to which acute care beds are inappropriately occupied by individuals in need of intermediate or longer term care, and the extent to which intermediate and longer term beds are, in turn, inappropriately occupied by individuals in need of safe and adequate housing in the community. This charge also specified that the Subcommittee study the Tripwire Agreement between New York City and the state.

This report is organized into three major sections. First, a brief descriptive background section highlighting demographic changes affecting the city, past and current hospital inpatient availability and use, alternative non-acute services and city-state agreements. Section II includes a summary of the major findings of the Subcommittee, while a final section presents the Subcommittee's recommendations.

Table I Population Changes 1970-1990—New York City

Age Group	Year 1970	1980	1990	Percent Change 1970-1990
0-19	2,474,275	1,987,796	1,829,414	(19.7)
20-44	2,641,086	2,640,615	2,744,798	3.9
45-64	1,832,137	1,491,496	1,347,069	(18.6)
65+	948,105	951,732	941,146	(.3)
Total	**7,895,603**	**7,071,630**	**6,862,427**	**(13.1)**

SOURCE: New York State Health Planning Commission, 1980 Projections From New York State Economic Development Board

I. BACKGROUND

Demographics

WITH OVER 7,000,000 RESIDENTS, New York continues to be the most populous city in the country. Not only is New York large but it offers striking contrasts—with some of the country's most expensive real estate, it also has literally hundreds of thousands of vacant and abandoned housing units, a disaffiliated street population estimated variously from 5,000-36,000 individuals,

Table II Psychiatric Patients By Age—New York City Hospitals—1981

Age Group	% of Psychiatric Patients	% Age Group is of all NYC Pop.	Pop. Change 1980-1990
0-19	11.8	28.1	(8.0)
20-44	56.4	37.4	3.9
45-64	18.3	21.0	(9.6)
65+	13.5	13.5	(1.1)
Total	**100%**	**100%**	**(3.0)**

SOURCE: Statewide Planning and Research Cooperative System, New York State Department of Health, 1981. Analysis provided by New York State Health Planning Commission, November, 1983.

over one million people on public assistance, 10.1 percent unemployed, while minority youth unemployment averages over 50 percent.

This combination of unemployment and the lack of suitable housing, coupled with a growing population of young adults in the city, has major implications for the mental health system, for these characteristics describe those most at risk for mental illness.

While the total population declined by 10.4 percent between 1970 and 1980 as depicted in Table I, the number of young adults remained unchanged and is now expected to increase. It is in this age group (20-44 years of age) that the onset of schizophrenia normally occurs.

Changes in the city's population between the 1970 and 1980 census are quite striking.

- The percent below poverty increased from 14.9 to 20.0
- The age cohort 20-44, while virtually unchanged in aggregate size, is quite different in its social composition—non-whites were 23 percent of this group in 1970 and now are 47 percent.

These changes all tend to increase the potential demand for mental health care, particularly since the age group 20-44 accounts for 56 percent of all acute psychiatric admissions while those age 45+ account for 32 percent of admissions.

Acute Capacity and Utilization

New York City, with 2,596 acute adult psychiatric hospital beds, has far more capacity per capita than virtually any other area of the state, and this supply has increased significantly since 1970. Table III reflects the total number of certified acute adult psychiatric beds in New York City by borough and auspice. It also displays the number of beds per 100,000 population for each borough. Currently, state-operated psychiatric centers

Table III Certified Acute Adult Psychiatric Beds by Borough and Auspice, New York City—1983

Borough	BEDS BY AUSPICE State	Voluntary/ Private	Municipal	Total	Beds Per 100,000 Population
Bronx	25	79	153	257	21
Manhattan	43	714*	401	1158	81
Queens	100	247	139	486	26
Brooklyn	150	182	264	596	27
Staten Island	25	74	0	99	28
Total	**343**	**1296**	**957**	**2596**	**36**

*Includes 231 private hospital beds

SOURCE: New York State Office of Mental Health, Bureau of Inspection and Certification, and New York City Regional Office, December, 1983.

account for 13.2 percent of acute adult psychiatric beds in New York City. The remainder are distributed as follows: voluntary hospitals 41 percent, municipal hospitals 36.9 percent, and private hospitals nine percent.

Hospital Utilization:

Occupancy rates for all hospital psychiatric units average well over 90 percent, with five hospitals averaging annual occupancy of 100 percent or greater. Table IV depicts psychiatric occupancy rates and average lengths of stay for all hospitals in New York City during 1982. This table reflects data for **all** psychiatric beds, not adult beds alone.

Table IV Hospital Psychiatric Unit Occupancy Rates and Average Lengths of Stay, New York City By Borough—1982

Borough	Occupancy Rate	Average Length of Stay
Bronx	99.1	21.1
Manhattan	92.2	23.4
Queens	93.2	23.1
Brooklyn	94.0	22.9
Staten Island	87.8	11.3
Total	**92.2**	**22.1**
	Voluntary Hospitals—92.2 Municipal Hospitals—91.3	

NOTE: Institutional Cost Reports do not separate adult psychiatric beds from all psychiatric beds.

SOURCE: New York State Office of Health Systems Management, Division of Health Care Financing, Institutional Cost Reports—1982

It should be noted that these occupancy levels are much higher than found in other large cities; e.g., Los Angeles 63 percent, Chicago 73 percent, Miami 79 percent and Philadelphia 84 percent. (See Appendix A)

Using data compiled from the Office of Health Systems Management, Uniform Statistical Reports and Institutional Cost Reports, and the Statewide Planning and Research Cooperative System, it is possible to track citywide occupany rates, average lengths of stay, discharges and total certified acute psychiatric beds. Three specific years were chosen for this review, 1975, 1980 and 1982.

Throughout the period, the number of annual discharges has decreased by 3.9 percent. During the same period of time, occupancy rates have remained consistently high, averaging well above 90 percent. This high level of occupancy is in part a function of increasing lengths of stay. In 1975 the average citywide length of stay was 19.4 days. By 1982 this figure had moved to 22.1 days for a 13.4 percent increase.

Table V depicts these and other findings, including changes in acute inpatient psychiatric occupancy rates.

Adult occupancy rates at the five state psychiatric centers are much more difficult to express, as there is no certified acute care bed capacity at two of the five hospitals. In these two hospitals, capacity fluctuates with

Table V New York City General Hospital Psychiatric Inpatient Utilization—1975, 1980 and 1982

Year	Discharges	ALOS	OCC Rate	Total Beds
1975	34,964	19.4	92.5	2,008
1980	34,413	20.0	89.3	2,099
1982	33,583	22.1	92.2	2,206

Note: ALOS = Average Length of Stay
OCC Rate—Average Annual Occupancy Rate

SOURCE: Office of Health Systems Management, Uniform Statistical Report (1975), Institutional Cost Reports (1980 and 1982) and New York State Department of Health, Statewide Planning and Research Cooperative System (1981). Analysis provided by New York State Health Planning Commission.

demand. Perhaps the best measure of aggregate demand, in the absence of occupancy rates, is admission data. During the period 1978-1982, the five state psychiatric centers in New York City admitted 52,254 individuals. This number, contrasted to the 50,000 admissions during the period 1972-1976, reflects an increase of 4.5 percent. Where source of admission is known, 58 percent of the adult admissions were from general hospitals. The "Tripwire" Agreement, reviewed later in this section, has been a significant factor in this increase.

A closer examination of the number of short-term admissions (length of stay of 90 days or less) can be used as a proxy for acute patients. This indicates a stable overall picture with a sharp increase at Kingsboro.

Table VI Discharges From State Psychiatric Centers In New York City—Patients With An Average Length of Stay of 90 Days Or Less 1980 and 1983

Facility	Discharges 1980	Discharges 1983	Change 1980 to 1983
Bronx P.C.	191	183	(4.2%)
Creedmoor P.C.	261	251	(3.8%)
Kingsboro P.C.	218	305	+39.9%
Manhattan P.C.	315	241	(23.5%)
Psychiatric Institute	43	30	(30.2%)
South Beach P.C.	178	178	-0-
Total	**1206**	**1188**	**(1.5%)**

SOURCE: New York State Office of Mental Health, November, 1983.

Alternate Care:

Not all patients in acute psychiatric units require hospital care. Information from both the Health and Hospitals Corporation and state psychiatric centers indicates that a significant number of patients are awaiting transfer to an alternate level of care. Table VII is a summary of alternate care patient data from surveys conducted by the New York City Health and Hospitals Corporation in 1981 and the New York State Office of Mental Health in 1982-83. These data reflect the appropriate alternate

care providers for patients in municipal hospitals and state psychiatric centers at the time of the surveys.

TABLE VII Alternate Care Needs of Psychiatric Inpatients—Selected Providers—New York City

Alternate Care Providers	Health & Hospitals Corporation	State Psychiatric Centers
Deemed to be Appropriate For Transfer To:		
State P.C. Care	61* (31.7%)	NA
SNF or HRF	24 (12.5%)	281 (20%)
Adult Home	17 (8.9%)	552 (39%)
OMR Placement	17 (8.9%)	-0-
All Other	73 (38.0%)	568 (41%)
Total	**100%**	**100%**
Total Patients Awaiting Alternate Care	**192 (20%)****	**1401 (30%)****

SOURCE: New York City Health and Hospitals Corporation—One Day Census, September, 1981.
New York State Office of Mental Health—Level of Care Survey, 1982-3.

*It is likely that the vast majority of these patients were admitted to a state psychiatric center within a short period of time.
**Percent of total psychiatric patient census (adults only) in state psychiatric centers.

The Statewide Planning and Research Cooperative System (SPARCS) data base was examined for alternate care for all New York City general hospitals with psychiatric units. This analysis indicated that patients aged 65 and over, with a primary psychiatric diagnosis, averaged 6.7 days awaiting alternate care services.

TABLE VIII Alternate Care Days Per Patient—Psychiatric Patients Age 65 and Over, New York City (1981)

Lowest Five Hospitals	1.4 days
Highest Five Hospitals	24.4 days
New York City Average	6.7 days
All Voluntary Hospitals	4.2 days
All Municipal Hospitals	18.6 days

SOURCE: Statewide Planning and Research Cooperative System, New York State Department of Health, 1981. Analysis provided by New York State Health Planning Commission.

This also shows that the Health and Hospitals Corporation has a severe problem. In fact, all of the six hospitals with the highest alternate care lengths of stay are Corporation facilities.

Patient Origin and Payor Status

An analysis of all psychiatric inpatients in New York City's voluntary, municipal and private psychiatric units (including alcohol and substance abuse patients) indicates that the vast proportion of all inpatients are residents of New York City. These data show that 89 percent of all discharges from hospitals in New York City during 1981 were from city residents.

Data collected on source of payment for these patients show a very high proportion of Medicaid patients and a low volume of Medicare, in marked contrast to other hospital inpatient services. Table IX illustrates this point.

TABLE IX Source of Payment—Psychiatric and Total Hospital Patient Days: New York City, 1980-81

Payor	Percent of Total Psychiatric Days*	All Patient Days**
Medicaid	44.3	21.4
Medicare	20.8	40.0
Blue Cross	13.9	19.4
Private Insurance	4.1	6.3
All Other	16.9	12.4
Total	**100.0**	**100.0**

*1981 data
**1980 data

SOURCE: Statewide Planning and Research Cooperative System, 1981, New York State Department of Health. Analysis provided by New York State Health Planning Commission.

Length of Stay

Total discharges from New York City general hospital psychiatric units have remained almost unchanged since 1975. During the same period, the average length of hospitalization has increased slightly for all hospitals, 19.4 days (1975) to 22.1 days (1982) and significantly in the Health and Hospitals Corporation, 13.4 days (1975) to 21.8 days (1982).

Examination by hospital indicates significant variations from the mean length of stay within New York City. The five lowest hospitals averaged less than 15 days while the five highest hospitals averaged over 29 days with respect to the average length of stay of psychiatric patients. In an analysis of length of stay data from the 1981 SPARCS data base, the most common diagnosis, schizophrenia, was examined. In an attempt to control for differences in patient characteristics, length of stay by hospital was age standardized and calculated only for those Medicaid patients who were not transferred to another hospital on discharge, who had no alternate care stay and who had no secondary diagnoses. These data are shown below.

Schizophrenia Length of Stay, New York City (1981)*	
Five Lowest Hospitals	13.5 days
Five Highest Hospitals	44.2 days
New York City Average	**24.3 days**

*Data are age adjusted with the following characteristics: no secondary diagnoses, no alternate care patients included; Medicaid patients only.

SOURCE: Statewide Planning and Research Cooperative System, New York State Department of Health, 1981. Analysis provided by New York State Health Planning Commission.

Alternatives to Inpatient Care

Inpatient acute care is but one segment of a complex network of mental health services. Particularly important to an effective continuum of care are the following services: access to long stay hospital care; skilled nursing facilities; crisis residences; community residences (supportive and supervised); day treatment (often called day hospital) and continuing treatment models; clinic and emergency services; psycho-social clubs, and sheltered workshops. All of these services are indeed available in New York City, but are generally considered to be inaccessible to much of the population as they are not distributed in proportion to need.

Table X indicates this maldistribution but also shows that significant expansion has occurred over the past several years.

TABLE X Growth of Community-Based Day Treatment Programs, 1975 to 1983 and Community Residence Programs/Beds, 1977 to 1983, New York City

	Day Treatment Programs		Community Residences Programs		Beds	
Borough	**1975**	**1983**	**1977**	**1983**	**1977**	**1983**
Manhattan	7	15	0	12	0	290
Bronx	5	6	0	8	0	218
Queens	1	6	1	13	40	384
Brooklyn	8	8	1	5	196	306
Staten Island	1	1	0	5	0	104
Total	**22**	**36**	**2**	**43**	**236**	**1302**

SOURCE: New York State Office of Mental Health, Bureau of Inspection and Certification, and New York City Regional Office, November, 1983.

The most dramatic day treatment program rates of increase occurred in Manhattan and Queens. Similarly, community residence beds showed a marked increase during the period, with major gains in every borough of the city.

City-State Agreements

*1. The Brooklyn Plan**

The Brooklyn Plan is a 1979 agreement among the major inpatient providers in Brooklyn, to redefine and coordinate services for the borough. Under this agreement, the entire borough is divided into three catchment areas with two state psychiatric centers, Kingsboro and South Beach, and one municipal hospital, Kings County Hospital Center, sharing responsibility for most of the acute inpatient care. Other municipal and voluntary hospitals providing acute care services in Brooklyn include Brookdale Hospital, Maimonides Hospital, Coney Island Hospital and Interfaith Hospital.

The plan has several attractive features—well-defined catchment areas, a single emergency service as the point of entry into all three acute services, a mechanism for dialogue between the providers, and a patient-centered treatment approach that promotes better continuity among state, city and community systems of care. The plan has resulted in the state psychiatric centers absorbing 4,000 of the 6,000 annual admissions previously experienced by the overtaxed Kings County Hospital Center.

This new division of service responsibility is in marked contrast to the former circumstances where Kings County Hospital Center was solely responsible for acute care, and the two state psychiatric centers provided only intermediate and long-term care. Each provider is now responsible for a comprehensive system of care to its portion of the borough. This revised system of patient care has improved service coordination and record keeping, enhanced closer contact with families of patients who now relate to one provider, and improved accountability. There are still service delivery problems

TABLE XI Emergency Room Transfers from Tripwire and Non-tripwire Hospitals to State Psychiatric Centers in the Bronx, Manhattan and Queens, November 1981—August 1983

Hospital		State Psychiatric Centers	Emergency Room Transfers to State P.C.s Weekend	Weekday
Health & Hospitals Corporation				
Bronx				
No. Central Bronx		Bronx	140	365
Bronx Municipal	Transfers	Psychiatric	0	33
Lincoln Hospital	To:	Center	0	48
Manhattan				
Harlem Hospital		Manhattan	523	129
Bellevue Hospital	Transfers	Psychiatric	0	2
Metropolitan Hospital	To:	Center	0	2
Queens				
Elmhurst Hospital		Creedmore	71	256
Queens General Hospital	Transfers To:	Psychiatric Center	407	986
Total			**1141**	**1821**

SOURCE: New York State Office of Mental Health, New York City Regional Office, November, 1983.

in Brooklyn but these relate to the quantity of services rather than the previous problems of acceptance or rejection of patients into various levels of care. There is now in fact increased pressure for additional inpatient hospital capacity. The plan is unique since it is one of the few examples of a negotiated strategy to coordinate the provision of mental health services among city, state and voluntary providers.

*See Appendix B.

*2. Tripwire Agreement**

In 1981, to alleviate overcrowding in two municipal hospitals, the City of New York and the New York State Office of Mental Health entered into the "Tripwire Agreement." This agreement allowed the Harlem Hospital emergency room to transfer patients to the Manhattan Psychiatric Center on weekends when the former was at 100 percent census. A similar arrangement between the North Central Bronx Hospital emergency room and the Bronx Psychiatric Center was also implemented with this agreement.

To illustrate the impact of the Tripwire Agreement, Table XI contrasts weekday and weekend emergency room transfers from tripwire and non-tripwire municipal hospitals to state psychiatric centers from November 1981 to August 1983.

*See Appendix C.

II. FINDINGS

FROM THE SUBCOMMITTEE'S ANALYSIS of data, presentations by invited experts and the broad experience of the Subcommittee members themselves, several critical and important findings or conclusions were reached.

Is there a crisis, or is there just the appearance of one? If real, can it be quantified? Interviews with key individuals involved with the mental health service delivery system and discussions within the Subcommittee have led to a conclusion that the crisis is a reality, virtually across the entire city. There is little evidence that psychiatric beds are occupied by those not very seriously mentally ill. In fact, there is evidence that patients are awaiting admission, often for extended periods of time in emergency rooms, while others who would indeed benefit from inpatient care cannot be accommodated since only the most sick, violent or suicidal patients can be admitted.

High occupancy often results in admission deferrals that would normally necessitate inpatient care. Some hospitals, due to a variety of external variables that lead to overcrowding, are often forced to care for patients on emergency room stretchers. Thus, occupancy rates are often reported in excess of 100 percent. The need for New York City's state psychiatric centers to transfer patients among themselves and to state psychiatric centers outside of New York City to alleviate overcrowding is a further illustration of the crisis. During the period July 1981 to March 1983, a total of 476 patients were transferred out of New York City, while an additional 84 patients were transferred between state psychiatric centers in the city.

In summary, the crisis can be illustrated by:

- High hospital occupancy rates, especially in adult units, commonly exceeding 100 percent for all of 1982.
- Evidence that a significant number of patients are daily waiting admission in emergency rooms.
- The inappropriate use of hospital beds due to a lack of access to non-inpatient care—20 percent of all psychiatric patients in municipal hospitals (1981).

This conclusion, however, merely displays the most obvious symptom of the problems of New York City's mental health system. An analysis of the underlying causes must address two key questions.

1. Are the current inpatient services being appropriately used?

This must include an examination of the appropriateness of admission and continued stay of patients presently being served. Are patients being admitted to inpatient care who could be served just as effectively in alternative programs such as day treatment, transitional housing or night hospital programs? Are patients' lengths of stay being extended not because of medical necessity but due to the lack of a suitable sub-acute program? Would the presence of intermediate care beds and increased crisis services help to alleviate the overcrowding of acute beds? Clearly, there is ample evidence that among all acute service providers some patients are indeed admitted and the length of stay prolonged due to the lack of alternative services.

2. Does the present network of mental health services sustain the mentally impaired in the community to the extent possible?

Effective *supportive* community programs with proper medical supervision can significantly reduce the demands for short-term inpatient care. To what extent are the high users of inpatient care served by these programs? Ideally, the use of these community programs can prevent, reduce or delay the need for inpatient hospital care. Perhaps of equal importance, a continuum of community programs can enable the timely discharge of hospitalized patients who no longer require acute care.

The four findings of the Subcommittee are briefly summarized below.

FINDING No. 1

Within New York City, virtually all providers of care to the mentally ill are under strain in a system that with some exceptions can provide only crisis care.

A central and consistent theme, pervasive throughout New York City, is one of high or over-utilization for all mental health providers. This factor is equally present in community-based services and in acute, intermediate and chronic care inpatient services. There is enormous pressure placed on all providers to serve only the most profoundly ill patients. Inpatient providers are always at or near maximum capacity. Community-based providers of therapeutic services are often unable to accept new patients since they are also virtually at or near capacity. Lastly, safe and adequate housing for the mentally ill in New York City is vastly insufficient to meet the demand.

FINDING No. 2

The quality of and access to appropriate care is seriously deficient in important ways; this contributes to the overcrowding but also is a consequence of the overcrowding itself.

This finding focuses on a series of often interrelated issues. High inpatient occupancy rates at hospitals, deficient numbers of appropriate community-based services and adequate housing have affected the quality of inpatient care. Hospitals are constantly under pressure to release acutely ill patients to provide open beds for emergency admissions. This system of pressures and responses often results in patients being inappropriately released to the community without adequate follow-up or being retained in high cost acute hospital beds awaiting placement in intermediate care beds, skilled nursing facilities and community residential settings. The resultant impact of this policy is the "revolving door" syndrome, wherein a significant proportion of mentally ill patients experience numerous hospital readmissions. Such acute psychiatric episodes may have been handled more appropriately had the system initially functioned more effectively.

Analysis of data from the Medicaid Management Information System (MMIS) indicates that during 1981, 41.5 percent of all Medicaid psychiatric acute inpatient days were utilized by only eight percent of all inpatients. Specific attention should be focused on this population to identify the reasons for this high inpatient utilization and alternatives to such care.

A second issue is one of the inappropriateness of using State psychiatric centers to care for the acutely ill patient experiencing medical problems. State psychiatric centers are neither designed, staffed nor equipped to treat acutely medically ill patients. A factor that exacerbates this problem is the weekend impact of the "Tripwire Agreement."

A separate though somewhat overlapping issue relates to the use of emergency rooms by general hospitals as holding areas for patients when inpatient beds are unavailable. This practice is becoming increasingly common in New York City and is a serious factor affecting the level of quality service rendered to these patients.

Lastly, there is a relatively high proportion of alternate care patients in general hospitals awaiting placement in other levels of care (e.g., nursing homes). This problem also exists within the state psychiatric centers where numerous patients are clinically ready for placement in community-based settings. Unfortunately, such services are unavailable to a large proportion of these patients.

The following three findings deal directly with the access to and quality of mental health care and are components of finding number two.

FINDING No. 2A

It is urgent that the additional acute care capacity already approved become operational as soon as possible and that vigorous actions to reduce the inappropriate use of current capacity be taken. The Subcommittee is not persuaded that still more acute care beds, other than in the Bronx, will be needed after these actions have been taken.

Acute care bed capacity in New York City would appear insufficient if occupancy rates are used alone as a proxy for need. At present there are 2,596 certified acute care adult psychiatric beds in New York City and an additional 394 beds approved though not operational. Table XII depicts the location and status of all certified and approved though not operational acute adult psychiatric beds in New York City (including state psychiatric center acute adult beds).

TABLE XII Status and Location of Acute Adult Psychiatric Beds in New York City October, 1983

	Certified Beds			Approved Beds Not Operational		
Borough	Pub.*	Vol.	Prop.	Pub.	Vol.	Prop.
Manhattan	444	483	231	43	71	9
Bronx	178	79	0	25	33	0
Brooklyn	414	182	0	60	38	0
Queens	239	247	0	0	15	100
Staten Island	25	74	0	0	0	0
Total	**1300**	**1065**	**231**	**128**	**157**	**109**

*Includes 343 state psychiatric center beds. (see Table III for breakdown)

SOURCE: New York State Office of Mental Health, New York City Regional Office, December, 1983

The addition of the 394 approved though not operational adult acute beds represents an increase of 15.2 percent over the present number of certified beds. These additional 394 adult acute beds will likely be operational by 1986. Of this number, 123 are in Manhattan, 58 are in the Bronx, and 115 are in Queens, the boroughs with the most significant problems of inpatient capacity. It should be noted that some of the approved but not

yet operational beds do not have a 9.39 designation. These beds will not have as significant an impact as those with a 9.39 designation. The 15.2 percent increase will be in addition to a 19 percent bed increase experienced since 1970. This will place New York City, relative to other major metropolitan areas, with a very favorable ratio of psychiatric beds to population. The Bronx, where significant acute care deficiencies are present, is the only borough that requires additional beds beyond those already approved.

Of the cities listed in Table XIII only Philadelphia has a psychiatric bed use rate close to New York's. Los Angeles County with 70.1 percent of New York's use rate and Chicago with 66 percent follow Philadelphia with 94 percent.

Table XIII Certified General Hospital Psychiatric Acute Care Beds and Patient Days, New York City and other Major Cities

City	Certified Psychiatric Beds	Beds per 100,000 Population	Patient Days Per 1000 Population
Miami	492	29	81
Chicago	947	32	84
Los Angeles County	2,903	39	90
Philadelphia	657	39	119
New York City	2,596	36	127

SOURCE: New York State data from New York State Office of Mental Health. Data from other cities obtained by Select Commission staff with assistance from New York State Health Planning Commission, October, 1983.

The high use of acute inpatient beds in New York is believed to be linked to the lack of alternative programs (Finding No. 2B) and poor coordination of services (Finding No. 2C).

FINDING No. 2B

There is an inadequate supply of capacity and programs that provide alternatives to acute inpatient care, which permit acute care beds to be used only for patients for whom that care is the most appropriate. Even on a short-term basis, marginal expansion of the alternatives can be achieved, thus helping to relieve the acute bed crisis.

Effective community treatment programs have a well documented record of delaying or preventing entirely the need for inpatient acute care. In addition, a well defined array of community services can shorten the length of necessary inpatient stays. Programs such as day treatment, intermediate care, skilled nursing facilities, community residences, transitional housing, and crisis intervention, along with family services, can play a major role in reducing the use of acute inpatient psychiatric care.

Evidence from the State's community residence program shows that effective community residences can dramatically reduce hospital admissions. The psychiatric literature has documented that approximately two-thirds of all hospital stays could be just as effectively treated in non-patient programs.* While this proportion may be lower in a city such as New York, it certainly is still significant. In fact, a recent study of New York City day hospital programs concluded that without a day hospital program, 62 percent of all those referred would have been otherwise hospitalized and 54 percent of all day hospital patients would have required longer hospitalizations.** The Subcommittee finds that the lack of a sufficient number of such alternative programs is a basic cause of the inpatient crisis.

Table XIV displays the imbalance of community programs across New York City and the uneven ratio of such programs to inpatient beds.

In Philadelphia, a city considered to have demographics somewhat comparable to New York's, there are 480 community residence beds and 657 acute inpatient beds, a ratio of .7 community residence beds to every hospital bed, in contrast to .5 community residence beds per hospital bed in New York City. California's "model" system requires five to nine alternative residential slots to every short-term hospital bed.

FINDING No. 2C

Fragmentation and lack of coordination create difficulties in caring for acutely ill patients. Better coordination can improve the situation marginally in the near future, but more substantially over time.

The system of mental health care in New York City is incredibly complex—with literally hundreds of providers in a multi-level of care service network. This is further compounded by the diversity of the municipal, state and voluntary agencies and their reliance on multiple sources of funding. Inadequate communication and coordination are also inherent difficulties. This is most in evidence with respect to the difficulties experienced in moving patients from one system to another and from one level of care to another.

A significant difficulty is the lack of clear criteria as to what patient programs are to serve patients with multiple and often conflicting patient care needs. For

*See for example Kiesler: "Mental Hospitals and Alternative Care," *American Psychologist,* April 1982, pg. 349-360; Stein and Test "Alternative to Mental Hospital Treatment," *Archives of General Psychiatry,* April 1980; Pepper and Rogatz: "The Young Adult Chronic Patient," *New Directions for Mental Health Services,* June 1982.

**New York State Psychiatric Institute, cited in *An Assessment of New York State Community Support Services Evaluation Studies: 1979-1983,* McGreevy et al, Office of Mental Health, 1983.

TABLE XIV Community And Acute Inpatient Capacity By New York City Borough—1983

Borough	Hospital Beds Per 100,000 Population	CR Beds Per 100,000 Population	Day Treatment Slots Per 100,000 Population	Ratio of CR Beds to Hospital Beds
Bronx	21	17	16	.8
Manhattan	81	19	38	.2
Queens	26	12	11	.5
Brooklyn	27	14	26	.5
Staten Island	28	30	18	1.1
Total	**36**	**18**	**22**	**.5**

Note: CR refers to community residence. It is not uncommon to find CR beds in one borough occupied by residents of other boroughs. Staten Island is a primary example with several of its CR beds occupied by Brooklyn residents.

SOURCE: New York State Office of Mental Health, Bureau of Inspection and Certification, November, 1983.

the patient with multiple needs whose care plan is changing, these barriers can often seem insurmountable. The core service agency concept in the community support services program (CSS) and effective case management should be emphasized across the mental health system. Mechanisms to regularly share information and discuss problem patients have been instituted as part of the Brooklyn Plan and are exemplary models which demonstrate significant improvements in patient care.

Another barrier to the timely movement of patients within the mental health system pertains to involuntary admissions. Section 9.39 of the Mental Hygiene Law, entitled: *Emergency Admissions for Immediate Observation, Care and Treatment,* requires designated hospitals to admit patients felt to have a "mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others." A 15-day involuntary hospitalization is permitted under this law, if within 48 hours of admission, a staff physician makes this determination. After the 15th day the patient's status must change.

At present in New York City, only 1540 of the 2549 acute psychiatric beds (excluding state psychiatric centers) or 60 percent, are designated as "9.39" beds. Table XV displays the distribution of these and total beds by borough and by auspice.

As depicted above, only 60 percent of the city's beds have a "9.39" designation. Large segments of New York City, especially in Manhattan and Queens have involuntary admission bed deficiencies.

FINDING No. 3

There are serious deficiencies in services to minorities, in part due to the lack of minority professional providers.

While access to mental health services is less than ideal for virtually all but the most affluent of New Yorkers, it is the city's large minority population which is often most disadvantaged, yet most in need. Particularly disturbing are significant variations in utilization by level of care. While for example, blacks are 27 percent of all those seen in the formal mental health system and 24 percent of the city's population, they are less likely to be served in voluntary hospitals than are whites, and less likely to receive clinic care. Additionally, Hispanics comprising 19.6 percent of New York City's overall population and 29 percent of the population under 21 years of age demonstrate similar utilization patterns. But beyond these numbers there are significant issues about the relevance and adequacy of care to all minority groups, the lack of minority professional and non-professional caregivers, and the lack of understanding of effective treatment for the city's non-white population, totalling 48 percent.

TABLE XV Section 9.39 Beds in New York City by Borough and Auspice—1983

Borough	Total All Beds	Section 9.39 Beds: Total Beds	Section 9.39 Beds: Percent of Total Beds	Section 9.39 Beds: Voluntary Hospital Beds	Section 9.39 Beds: Municipal Hospital Beds
Manhattan	1237	711	57%	263	448
Bronx	248	201	82%	32	169
Brooklyn	528	362	69%	122	240
Queens	452	211	47%	25	186
Staten Island	84	55	65%	55	0
Total	**2549**	**1540**	**60%**	**497**	**1043**

SOURCE: New York State Office of Mental Health, New York City Regional Office, November, 1983.

FINDING No. 4

The mission, clients and services of the mental health system are often poorly understood and the public is ill-informed about the capabilities and limitations of mental health treatment.

There appears to be a high level of public misinformation about mental illness as a disease and methods of caring and treatment. The high proportion of chronicity and the associated services required to deal with the long-term nature of mental illness are factors that are generally misunderstood. Deinstitutionalization and its impact on the public perception of mental illness has led to inaccurate and unfortunate generalizations that ignore the fact that there is no cure for most forms of chronic mental illness for which lifetime care is the rule not the exception.

The Subcommittee finds that more reasoned and realistic expectations must be developed for the mental health care system and clearer distinctions should be made to define mental health versus social service and general health responsibilities.

III. Recommendations

The Subcommittee offers a series of recommendations that when taken as a whole offer significant and practical steps designed to address a very difficult and complex problem.

These recommendations are based on the principle that state and city governments, in conjunction with the voluntary mental health sector, share a mutual commitment for service to the mentally ill in New York City. Only when all of these parties work together in a true partnership can the mentally ill be effectively served. Failures in communication and unclear and duplicative roles and responsibilities have long prevented effective coordination of services.

The following short-range recommendations are those that can lead to tangible results within one year. Long range recommendations will require more than a year to yield results. The Subcommittee urges that movement toward implementation of the short-term recommendations begin without delay, whereas the long-term recommendations should be addressed by the full Select Commission in its deliberations.

SHORT-TERM RECOMMENDATIONS

The following 16 short-range recommendations have been divided into six distinct categories, namely: New York State financial support, new bed capacity, interhospital transfers, facilitating patient flow, improving services to minorities, and serving the homeless. This categorization highlights those recommendations that will have a direct bearing on easing the acute inpatient crisis. It also focuses on additional recommendations to improve the overall system of mental health care in New York City.

NEW YORK STATE FINANCIAL SUPPORT

RECOMMENDATION NO. 1

Additional funds are urgently needed to maintain the present capacity of the mental health system and permit some expansion of services necessary to remedy the worst and most pressing defects. New resources, and not simply a redistribution of current funding, are necessary.

The Subcommittee views this recommendation as a basic tenet from which subsequent recommendations flow. Any new state funding approved for the remaining recommendations in this report should not be at the expense of presently funded programs in New York City. The Subcommittee urges that funding for local assistance and state psychiatric hospitals in New York City, *at a minimum,* not be reduced. Further, it is recommended that personnel losses sustained at New York City's state psychiatric centers since April 1, 1983 be recovered, including positions providing services to children and youth, that inflationary increases for local assistance-funded service be continued and that restoration of the bad debt and charity pool offset occur. Finally, the Subcommittee would urge that the reimbursement methodology for general hospitals not be modified to discourage hospitals from providing psychiatric care, such as the establishment of separate rates for inpatient psychiatry.

NEW BED CAPACITY

RECOMMENDATION No. 2

All the state and city agencies concerned must move swiftly to assure the opening of approved but not yet operational acute care beds, approve the establishment of new beds in the Bronx, and assure that the changes at Bellevue result in a minimal reduction in operating bed capacity.

1. Expedite the opening of the 25 approved psychiatric beds at North General Hospital. The state should move to assist North General Hospital in opening these beds or find another suitable applicant who can proceed.

2. The Article 28 application pending in the New York State Office of Health Systems Management to establish 115 additional psychiatric beds on the 18th floor of "New" Bellevue should be approved without delay. When certification is received, Bellevue Hospital should make every effort to see that these beds become operational as soon as possible. As an interim measure, an Article 28 application should be submitted by Bellevue and approved by the state allowing for the temporary conversion of medical/surgical beds to psychiatric beds for a two-year period.
3. Expedite the opening of all approved but not yet operational psychiatric beds in New York City—394 beds. (See Appendix D)
4. Additional acute care bed capacity at general hospitals and increased alternative services in the Bronx should be applied for, approved and expedited.

The Subcommittee supports the notion that a state children's psychiatric center be established in Brooklyn. In addition, steps should also be taken to assure that all of these new resources accept 9.39 patients and serve designated catchment areas.

INTER-HOSPITAL TRANSFERS

RECOMMENDATION No. 3

The Tripwire Agreement is a temporary and less than ideal stop-gap measure and should be phased out as new acute care beds are opened and other steps to relieve the acute care system are taken. This will require aggressive effort by both city and state governments to put in place the additional resources which will eliminate the need for Tripwire. It is the intent of the Subcommittee that these actions will result in ending the need for Tripwire within 18 months of the approval of this report by the Governor. Meanwhile, the workings of Tripwire should be smoothed by allowing a more uniform movement of patients during the week without increasing the overall volume of transfers.

The Subcommittee regards the Tripwire Agreement as a temporary and less than ideal stop-gap measure. Clearly, the quality of patient care suffers under this arrangement and accountability is weakened while state hospitals are overburdened. The Subcommittee also wishes to emphasize the importance of moving to make changes which will allow the Tripwire Agreement to cease. Therefore, beginning with the approval date of this report by the Governor, the Tripwire Agreement will cease to exist 18 months hence or on a borough by borough basis, as the new psychiatric beds noted in the present Tripwire Agreement become operational. It is essential that New York State and New York City governments take timely and aggressive actions to minimize or eliminate the need for this Agreement.

RECOMMENDATION No. 4

Transfer of patients awaiting the completion of commitment procedures should be authorized. The director of the receiving hospital should be substituted for the director of the waiting hospital as the appropriate party in the civil court proceeding.

Inpatients in municipal hospitals who are the subject of judicial court commitment procedures may not be transferred during the pendency of these procedures and since these procedures can take two to three weeks, transfer is delayed. This recommendation would eliminate the delay by allowing a transfer to occur during the pendency of the commitment. The director of the receiving hospital would then be a party in the court action. This will release municipal hospital acute psychiatric beds for community patients.

RECOMMENDATION No. 5

The New York City Health and Hospitals Corporation should give high priority to improving ambulance service for inter-hospital transfers of psychiatric patients.

At present, the New York City Health and Hospitals Corporation has six ambulances equipped to transfer psychiatric patients between hospitals. Unfortunately, funding to staff and maintain these vehicles is insufficient. This results in psychiatric patients being required to wait in hospital emergency rooms, often for several hours, prior to being transferred. These delays also negatively impact on the hospital's emergency room staffs. This recommendation seeks increased efforts by the Health and Hospitals Corporation to alleviate this problem.

RECOMMENDATION No. 6

The New York State Office of Mental Health should develop and publish uniform admission standards for all state psychiatric centers in New York City.

To minimize or eliminate the confusion caused by a lack of uniformity, the New York State Office of Mental Health should establish uniform citywide admission

criteria. This will reduce the need for multiple transfers and establish clear systemwide benchmarks for all providers.

This recommendation, linked with recommendation No. 13 dealing with the creation of borough clinical committees, will lead to a better understanding of where patients with special needs should be treated. In addition, this would foster uniformity among providers in the determination of the appropriate level of care needed by all patients. This is a particularly important problem between acute hospitals and state psychiatric centers which often disagree on definitions of which patients require transfer into the state system for intermediate and long-term hospital care. As clear admission standards are developed and adopted, these differences will diminish, leading toward a defacto "no decline" policy (where general hospitals' request for the admission of patients into psychiatric hospitals are all accepted).

FACILITATING PATIENT FLOW

RECOMMENDATION No. 7

The New York State Offices of Health Systems Management and Mental Health should quickly develop rates for hospital-based day treatment programs which will lead to the expansion of such programs in New York City and prevent the threatened closure of existing programs.

Hospital-based day treatment programs have been deterred by the lack of equitable reimbursement arrangements. New or expanded intensive hospital-based day treatment programs often cannot be supported, based on the present rate reimbursement structure.

Among hospitals offering day treatment services, actual costs vary from $60 to $300 per visit reflecting differences in cost accounting and services offered. The development of new cost standards, as well as new programmatic standards that define a more intensive level of care for hospital-based programs, is essential.

The New York State Offices of Mental Health and Health Systems Management should immediately initiate the development of standards defining who should be served, including utilization norms and productivity measures so that day treatment services may be more adequately defined. When available, these standards and productivity measures would be used by the Office of Health Systems Management to compute Medicaid day treatment rates to permit the addition of greatly needed day treatment program capacity.

It is expected that the increased availability of targeted intensive day treatment services in areas of greatest need, coupled with increased housing opportunities, will have the effect of reducing the average length of acute psychiatric inpatient stays in general hospitals by two days. In addition, steps should be immediately taken to provide interim rates where necessary to prevent the closure of currently operational hospital-based day treatment programs and to permit the earliest possible opening dates for new and expanded capacity. A target of adding 150 day treatment slots is recommended for 1984-85.

RECOMMENDATION No. 8

Steps should be taken to assure that hospital psychiatric patients appropriate for nursing home care are not rejected for admission simply because of their mental impairment.

A significant number of psychiatric patients in municipal, voluntary and state hospitals require nursing home care. Often, because of simple discrimination, these patients find it exceptionally difficult to gain admission to nursing homes. Several steps should be undertaken by the New York State Office of Health Systems Management and the Health Systems Agency of the City of New York, Inc., including the targeting of a major proportion of the new nursing home capacity expected to be approved over the next several years for psychiatric patients, an examination of special considerations for increased nursing home rates if it can be demonstrated that these patients require more costly care, and the identification of measures to prevent nursing homes from discriminating against the mentally ill. It is also recommended that priority access to skilled nursing facility (SNF) beds be given to Section 9.39 acute care facilities.

RECOMMENDATION No. 9

The state should move to establish 200 intermediate care beds in state psychiatric centers to reduce the inappropriate use of high cost general hospital acute inpatient services by patients who require this level of care.

It was agreed that a significant number of acute patients in general hospitals are unnecessarily utilizing such beds. These patients do not require the highly intensive and costly services provided in general hospitals. Therefore, it is recommended that as acute care beds are reduced, 200 new intermediate care beds be established at state psychiatric centers in New York City. This will help assure that capacity will be available to provide intermediate hospital care to patients who have been stabilized in general hospital acute units, thereby releasing acute beds for new patients.

RECOMMENDATION No. 10

Serious consideration should be given to the establishment of transitional beds to relieve pressure on general hospital inpatient psychiatric capacity.

The concept of transition beds applies to the use of a discrete number of specially reimbursed beds at general hospitals to be used for patients no longer requiring intensive and expensive acute care services. These beds would be used for short lengths of stay by patients on alternate care status. This concept assumes that a revised reimbursement methodology will be established so that the per diem rate for transitional care will be less than that for acute care.

RECOMMENDATION No. 11

The state should expedite procedures for the development of new community residence beds by the voluntary and public sectors. In addition, the construction of new community residence beds on state psychiatric center grounds, where cost-effective and feasible, is recommended.

There are presently many community residence beds in the certification "pipeline" that should be expedited. These beds are urgently needed in the community and the New York State Office of Mental Health should take necessary actions to reduce all delays with respect to this process. By March 31, 1984, 1,362 beds will be established in New York City. An additional 231 beds are recommended for development in 1984-85. These new beds will be developed according to the revised community residence program and funding models and will emphasize services to more active, volatile younger chronic patients.

Given community level opposition to the location of community residences in residential neighborhoods, the Subcommittee recommends that where available, the grounds of state psychiatric centers be used as sites for new construction.

RECOMMENDATION No. 12

The State Offices of Mental Health and Health Systems Management should implement a targeted demonstration program designed to increase the role of private professional practitioners in caring for patients who now rely entirely on the public psychiatric care system.

This demonstration effort would streamline administrative procedures for Medicaid reimbursement to encourage private practicing mental health professionals to assume a larger role in case management and care delivery responsibilities in areas of greatest need. The Subcommittee believes that reduction in paperwork and cumbersome administrative procedures in a carefully structured manner could attract psychiatrists to either enter the Medicaid program as providers or expand their present practice. Anticipated results include reduced levels of inpatient care and enhanced continuity of care for the enrolled Medicaid clients. The Subcommittee also urges the direct inclusion of the professional community in the design of this project.

RECOMMENDATION No. 13

Providers in each borough of the city should establish clinical committees to discuss problem cases on a regular basis.

The creation of borough-wide and sub-borough (where appropriate) clinical coordinating committees can enhance the communication among and between both inpatient providers and other community programs and can serve to minimize conflict and lack of coordination present in the system. Regular sessions to discuss problem cases will be beneficial to both providers, patients and those administratively responsible for the mental health system in New York City.

IMPROVING SERVICE TO MINORITIES

RECOMMENDATION No. 14

Although some of the steps may take time to show results, the state, city and voluntary sectors should begin now to implement measures to serve more effectively the city's minority population, in particular, the need for more minority professional providers. In addition, the Subcommittee emphasizes the need for attention to the special needs of minorities in the implementation of all the recommendations in this report.

These efforts would include measures designed to strengthen the inservice training of mental health personnel in the unique treatment needs of the city's minority population, new definitions of treatment modalities to deal with illnesses that affect minority populations and increase the numbers of minority health personnel. In addition, progress should be made in assuring that

the proportion of minorities served by mental health providers is consistent with the proportion of minorities residing in the community served.

Specific short-term actions that will have a positive impact on mental health service to minorities include:

- The establishment of an Associate Commissioner position and a designated minority clinical services capacity in the New York State Office of Mental Health's Office of Minority Affairs, to have programmatic responsibilities for improving mental health service to minorities, including input into New York State budget decisions.
- A study/advocacy group should be established mirroring the Presidential Commission on Mental Health, Subcommittee on Minorities, with appropriate staff to determine the specific treatment needs and make recommendations to increase the relevancy and amount of programming for minority New Yorkers.
- State and local governments and the voluntary sector should, in conjunction with the Office of Mental Health, form a State Institute for Research and Development. This institute should create training methods and conduct seminars and inservice training programs for all levels of mental health workers to improve mental health service to minorities.
- Responsibility for all Office of Mental Health minority demonstration projects should be transferred to the Office of Minority Affairs.
- The New York State Governor's Interagency Council should be reactivated to enhance coordination among and between state agencies relative to minority mental health issues.
- Programs to train or retrain minority mental health professionals and non-professionals in the mental health field should be developed and fostered by persons knowledgeable about New York City minority issues.

SERVING THE HOMELESS

RECOMMENDATION No. 15

The state and city should increase their efforts to provide mental health services to the homeless, especially severely disabled "street people" who do not use the current shelter system, by establishing specialized residential programs at Creedmoor Psychiatric Center and expanding outreach services citywide.

Recent studies suggest that the mentally ill are a substantial segment among the homeless population with a significant proportion seriously impaired.

Mentally ill homeless persons have the same basic needs for shelter, nutrition, health services, social support, etc., as other homeless persons. While psychiatric disability is a problem which complicates the meeting of these basic needs, the lack of these resources also exacerbates the psychiatric condition. Solutions to the problems associated with the homeless go far beyond providing adequate shelter. The problems also encompass health and mental health care needs. Solutions via expanded services should be focused directly on these needs.

To better meet the psychiatric needs of this population, the following is proposed:

- Establishment of specialized shelter, domiciliary care and community residence beds for the homeless mentally ill at Creedmoor Psychiatric Center.
- Expansion of outreach programs including additional programs for Harlem/Upper East Side, the Bronx and Brooklyn.
- Increased efforts by the city's public and voluntary mental health service providers to render appropriate care to the homeless population.

RECOMMENDATION No. 16

The New York State Office of Mental Health, in conjunction with the New York City Department of Mental Health and the Health and Hospitals Corporation, should implement a model program to evaluate the impact of a coordinated and integrated mental health service system on a pilot basis.

This recommendation proposes the development of two community service system model programs—one under voluntary auspice to be chosen via a request for proposal process and the other under municipal auspice. In each model, a single authority will be assigned comprehensive service and administrative responsibility for a defined group of patients to minimize service fragmentation. This demonstration is not intended to identify new concepts and strategies, but to systematically apply knowledge already known on service management and strengthen the coordination of services. The demonstration will provide increased access to a broad range of services and improve the integration of services. Effective case management will be a key emphasis of these demonstrations, as will the creation and maintenance of a patient data base for client assessment, monitoring and evaluation. The evaluation aspect of this project should be the responsibility of an independent organization.

This would involve the responsible management authority (a voluntary or city unit) to take responsibility for the following:

- Develop a service plan with utilization targets for a defined mentally ill population.
- Take responsibility for monitoring utilization, admission, continuous stay and discharge of all defined patients.

- Develop workable agreements with providers—city, state and voluntary—for necessary care.
- Establish a management capability to monitor system performance with specific goals to maintain the patient in the community.

LONG RANGE RECOMMENDATIONS

While the Subcommittee focused on short-term recommendations, it was clear that there were several overarching problems that needed resolution. The Subcommittee suggests that the full Select Commission consider the following long-term recommendations during its deliberations over the next several months.

RECOMMENDATION No. 1

There should be one administrative authority responsible for the coordination of mental health services in New York City.

At present, there is no single focus for decision-making in New York City. The New York City Department of Mental Health, the Health and Hospitals Corporation, the voluntary sector, and the New York City Regional Office of the New York State Office of Mental Health, all provide systemwide and often service specific direction but without sufficient coordination. There is a serious lack of clarity regarding the responsibilities and roles of each agency with competing and often conflicting objectives. This leads to administrative confusion and compounds the inherently complex job of delivering effective mental health services. It is imperative that the administrative leadership of the New York City mental health system agree to identify one administrative authority so that decisions concerning the coordination and provision of services may be made centrally.

RECOMMENDATION No. 2

The City of New York should develop discrete service or catchment areas for all providers, with arrangements in each area to provide directly or arrange for access to a full range of institutional and community-based mental health services.

The creation of a citywide catchment area system would stimulate enhanced coordination and integration between hospital-based and community therapeutic and rehabilitative providers. A logical and efficient system of providing a full range of mental health services to the residents of each catchment area would be stimulated if this formed the basis for working groups of community providers to coordinate services. Each catchment area should ultimately have an adequate supply of providers equipped to render a full range of services with defined agreement for the regional delivery of specialized, costly or infrequently used programs.

RECOMMENDATION No. 3

The roles of inpatient care providers should be redefined and clarified between the state and municipal/voluntary sectors.

The present system of voluntary, municipal and state hospitals providing all levels of care is inefficient and inappropriate. The appropriate role(s) of each of these service sectors should be defined and systemwide changes should be implemented. The Subcommittee would support efforts to have state psychiatric centers focus on intermediate and long-term care only with municipal and voluntary hospitals providing virtually all acute care. In addition, the Subcommittee would urge that steps be taken to require that all hospitals receiving public funds accept 9.39 patients and serve defined catchment areas. This is a fundamental issue for consideration by the full Commission.

RECOMMENDATION No. 4

The long-term development of a range of community-based services should be stimulated by state and city governments.

A lasting resolution to the problems associated with acute care rests with the establishment of a community-based service system that focuses on alternatives for the chronically mentally ill. Significant additions are required to the service system, particularly day treatment programs, crisis intervention services, vocational rehabilitation and a variety of supportive and supervised housing arrangements. It is anticipated that additional community-based services will lessen the reliance on hospital inpatient care in New York City. In addition, the appropriate use of case management services should be utilized where possible. The service system in Philadelphia, though dissimilar to New York City's, perhaps represents a better service configuration. The number of inpatient beds and patient days per 100,000 population and community residence beds is in dramatic contrast to that of New York City. Major strides should, therefore, be taken to move closer to the balance found in Philadelphia.

RECOMMENDATION No. 5

Providers of mental health services should improve services to the city's large minority population.

Efforts should be undertaken to (1) strengthen the training of mental health personnel and referral agencies in the unique treatment needs of the city's minority populations: (2) reduce the barriers to service utilization by hiring personnel that share the language and culture of the patient population; (3) increase the number of clinically trained minority administrative staff involved in the development and implementation of program policies affecting minority populations; and (4) assure that the proportions of minority providers are equivalent to the proportions of minorities residing in the communities they serve.