NEW YORK STATE LEGISLATURE

2011-2012 JOINT BUDGET HEARING

MARCH 2 - 12:30

MENTAL HYGIENE

HEARING ROOM B
LEGISLATIVE OFFICE BUILDING

NYS Office of Mental Health	Michael F. Hogan Commissioner
NYS Office for People with Developmental Disabilities	Jim Moran Acting Commissioner
NYS Office of Alcoholism and Substance Abuse	Arlene Gonzalez-Sanchez Commissioner
Mental Health Association In New York State	Glenn Liebman CEO
Association for Community Living	Toni Lasicki Executive Director
National Alliance for Direct Support Professionals	Theresa Laws
Jewish Board of Family & Children Services	Carman Collado Director of Public Policy & Government Relations
NYSARC	Ben Golden Director of Governmental Affairs

NYS Association Of Psychiatric Rehabilitation Services	Harvey Rosenthal President
NYS Coalition for Children's Mental Health Services	Andrea Smyth
Alcoholism & Substance Abuse Providers of New York State	John Coppola Executive Director
NYS Rehabilitation Association, Inc.	Jeff Wise President & CEO
Families Together in NYS	Paige Pierce Executive Director
Mental Illness Policy Organization	D.J. Jaffe Founder
Supportive Housing Network of NY	Ted Houghton Executive Director
Cerebral Palsy Association Of NYS	Susan Constantino President & CEO
Legal Services Funding Alliance	Lillian Moy Representative
National Alliance on Mental Illness (NAMI)	Sherry Grenz President
	Paul Klein Program Director
Developmental Disabilities Alliance Of WNY	Michael Gross DDAWYN Government Affairs Chairperson

JOINT LEGISLATIVE FISCAL COMMITTEES BUDGET HEARING
State Fiscal Year 2011-12 Executive Budget

March 2, 2011

Michael Hogan, Ph.D., Commissioner
NYS Office of Mental Health

Good morning Senator De Francisco, Assemblyman Farrell, Chairman McDonald, Chairman Ortiz, and distinguished members of the Senate and Assembly Finance and Standing Committees. I am Michael Hogan, Commissioner of the Office of Mental Health (OMH), and I appreciate the opportunity to discuss the Office of Mental Health's portion of the State Fiscal Year 2011-12 Executive Budget and how it will support the agency in providing care to over 650,000 individuals with mental illness who are served in New York's system annually.

Governor Cuomo has said very directly what New Yorkers know: our state has been spending beyond its means for far too long. He has made it clear that excessive spending must stop. The proposed Executive Budget is a blueprint for the redesign of State government and the vehicle to put New York on the road to recovery.

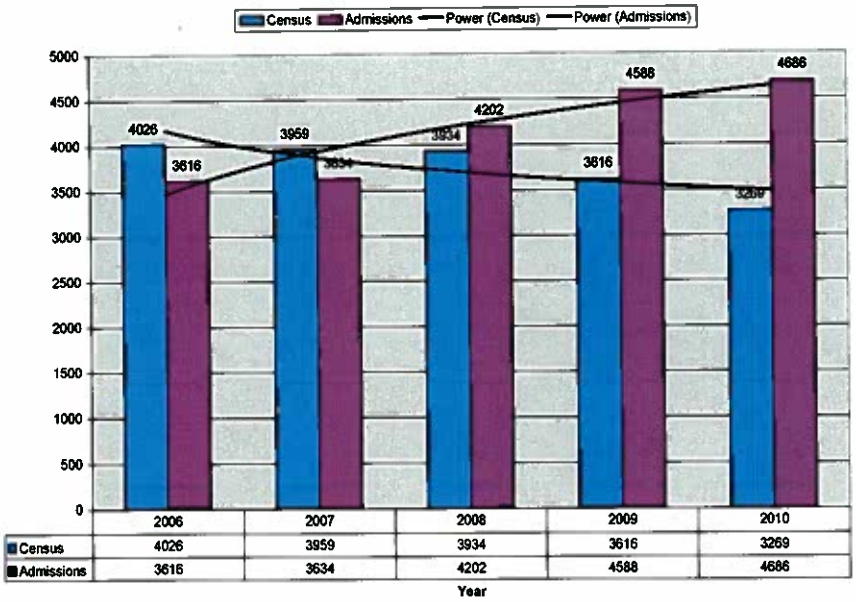
While the budget challenges shareholders of the public mental health system to work together to close the budget gap, it is a responsible approach that reflects the Governor's continued commitment to maintaining access and availability of community supports to both adults and children.

Mental health problems are prevalent and troubling, with one in ten Americans affected by mental illness that is serious enough to affect functioning every year. But most people with a mental illness get no care. The health system in general has a long way to go to detect and treat mental illness. Therefore, the core mission of OMH is to operate and oversee a "safety net" of community and hospital services, especially for adults with serious and persistent mental illness, and children and youth with serious emotional disturbance. The Governor's proposed budget continues to support that core mission while asking that OMH, like all agencies, find ways to reduce operating costs.

We are ready to find ways to reduce costs while preserving quality of care. The Executive Budget proposal provides the Office of Mental Health with the necessary flexibility to determine the most appropriate and effective way to deliver State-operated services based on a variety of factors, including fiscal and programmatic needs and the demand for care.

As illustrated in the chart below, OMH has made substantial gains to improve the efficiency and productivity of its hospitals.

Figure 1
Adult Census & Admissions by Year



	2006	2007	2008	2009	2010
Census	4026	3959	3934	3616	3269
Admissions	3616	3634	4202	4588	4686

Year

During 2010, there were 4686 admissions to the adult hospitals, a 29% increase since 2007. We were able to achieve that while operating fewer beds with fewer staff. The appropriateness of hospital care has also improved, in part because of the Transitional Placement Program (TPP) initiated in fiscal year 2009-10. TPP's are inpatient units converted to residential settings, providing a "step down" experience for people who have often been in the hospital for years, but need support for a successful move back to their community. Overall, the quality of care at OMH remains very high, and the Joint Commission (TJC), which accredits over 95% of all hospitals in the United States, during surveys conducted in 17 OMH hospitals in 2010, ranked our performance as surpassing the norms in private medical centers. Hospital surveys by TJC and other inspectors will continue, and we are firmly committed to maintaining the quality of care.

The Aid to Localities portion of OMH's budget supports over 2,000 treatment and support programs that are the community side of the mental health safety net. Most spending in mental health community programs involves Medicaid and in recognition of that, OMH is a participant in the Governor's Medicaid redesign team. New York's mental health community has been united in recommending that mental health care in Medicaid be better coordinated by qualified Behavioral Health Organizations, and that people with serious mental illness can be better served in Health Homes. We are pleased that the MRT has accepted these recommendations. OMH also continues to implement Clinic Restructuring, which emerged from legislative recognition of inequitable clinic reimbursement. Restructuring will align financing with quality expectations, improve consistency and compliance with federal requirements, and address New York's vulnerability against Medicaid payment rules.

Governor Cuomo has clearly articulated the need for all parts of government to achieve costs savings and efficiencies in response to the fiscal crisis facing the state. We are committed to doing our part. We will continue dialogue with our stakeholders, not only on the budget but also on changes that the Office of Mental Health can make to deliver services effectively and efficiently. Our mission of advancing recovery and resiliency for persons with mental illness and emotional disturbance will continue to guide our efforts.

Thank you again for the opportunity to address you today. I welcome your questions and comments.

Andrew M. Cuomo
Governor

James F. Moran
Acting Commissioner

NYS Office For People With Developmental Disabilities

Putting People First

Governor Andrew M. Cuomo's 2011-12 Executive Budget

Joint Legislative Fiscal Committees Budget Hearing

Testimony of New York State Office for People With Developmental Disabilities (OPWDD)

March 2, 2011

JOINT LEGISLATIVE FISCAL COMMITTEES BUDGET HEARING

State Fiscal Year 2011-12 Executive Budget

March 2, 2011

James Moran

NYS Office for People With Developmental Disabilities

Good morning Senator DeFrancisco, Assemblyman Farrell, distinguished members of the Senate Finance and Assembly Ways and Means Committees, Assemblyman Ortiz and Senator McDonald. Thank you for the opportunity to discuss Governor Cuomo's Executive Budget as it relates to the Office for People With Developmental Disabilities and supports our mission of helping people with developmental disabilities live richer lives. I am Jim Moran, Acting Commissioner of the Office for People With Developmental Disabilities.

Governor Cuomo's Executive Budget lays out a plan that will lead this State to recovery by eliminating historic budget deficits and transforming the way that government does business. The Governor has charged me, as he has done with the heads of all State agencies, with helping to achieve these objectives in a fair and responsible manner. At the Office for People With Developmental Disabilities (OPWDD), we will restructure the way in which services are delivered so that they remain person-centered and responsive to the needs of those we serve, but we will do so more efficiently while maintaining quality. The agency has strong partnerships with individuals with developmental disabilities, their families, advocates, our provider agencies and other stakeholders, and I will look to them to help us carry out our core mission and achieve the goals established by the Governor.

OPWDD serves more than 126,000 New Yorkers with developmental disabilities, which include autism, epilepsy, cerebral palsy, and neurological impairments. In recent years, New York has made great strides in improving its methods of delivering services to this vulnerable population, moving more people from institutions to the community than any other state in the nation. In addition, OPWDD continues to place greater emphasis on individual choice, opportunities that support greater independence and integration into the community, improved sustainability, and satisfaction.

The Governor's Executive Budget accomplishes two important goals – it eliminates the State's deficit and creates structural changes that will transform State government for years to come. Governor Cuomo has said that the first step toward recovery must be to reduce State spending. As part of its commitment to restructuring and right-sizing government, the Governor's 2011-12 Executive Budget proposal for OPWDD contains savings actions that continue to support the agency's investments in the core, mission-critical supports and services that people with developmental disabilities and their families need. The overall recommendation maintains the State's commitment to support a wide range of New Yorkers with developmental disabilities, including those who are medically frail, behaviorally challenged, those with autism, those who have been placed out-of-State or who are "aging out" of education, as well as those living with their families.

Individuals with developmental disabilities living at home will be offered a variety of safety net services, including family support services that provide opportunities for families and individuals with disabilities to be supported in their own home and day supports. Safety net services are critically important during times of economic downturn, and the Governor has committed funds to preserve the availability of and access to such services. To ensure that services will be there for those who need them, the Executive Budget recommendations include funding to support 2,300 lower cost residential and non-residential opportunities. In addition, these investments offer families, who keep their loved ones at home, the supports and services they need to be able to keep their jobs, contribute to New York's economy, and remain intact; all of which are longer term benefits to New York's social and economic fabric.

Answering the Governor's call to change the culture and dynamic of government, OPWDD has set foot on a path to improve the effectiveness and sustainability of our system of supports and services to individuals with developmental disabilities, making sure we provide individuals the right services in the right setting and at the right price. OPWDD sees opportunities today and in the future where we can help to maximize opportunities to support all persons with developmental disabilities and to ensure they enjoy meaningful relationships with family, friends, and others in their lives; experience personal health and growth; live in homes of their choice; and fully participate in their communities.

Like Governor Cuomo, I look forward to working with all of our stakeholders and the Legislature to address the challenges before us, emerge a stronger state and ensure that people with developmental disabilities are able to live the richest lives possible.

Thank you.

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JOINT BUDGET HEARING OF THE LEGISLATIVE FISCAL COMMITTEES

State Fiscal Year 2011-12 Executive Budget
March 2, 2011

Commissioner Arlene González-Sánchez
NYS Office of Alcoholism and Substance Abuse Services

Good morning Senator DeFrancisco, Assemblyman Farrell, distinguished members of the Senate Finance and Assembly Ways and Means Committees, Senator Klein and Assemblyman Cymbrowitz. My name is Arlene González-Sánchez and I am the Commissioner of the Office of Alcoholism and Substance Abuse Services.

The Office of Alcoholism and Substance Abuse Services (OASAS) oversees an addiction services system that serves 110,000 New Yorkers on any given day. New York's treatment services are provided in inpatient, outpatient and residential settings. Our agency's mission is to improve the lives of all New Yorkers by leading a premier system of addiction services through prevention, treatment and recovery.

Governor Cuomo acknowledges that the State is at a crossroads and his Executive Budget lays out a recovery plan to transform government. This plan, which is both a blueprint and a management tool designed to recalibrate our government and rebuild our economy, will give us the opportunity to re-align our agency and ensure that our resources are utilized in a targeted way that best serves New Yorkers while working towards establishing a more efficient and effective state government.

The Executive Budget allows us to achieve this goal by maintaining support for critical prevention, treatment and recovery services that are core to our system. In addition, the Executive budget continues the current year levels of funding for OASAS costs related to recent drug law reforms, including maintaining 250 residential beds added in 2010-11. This support, along with the actions that we will take, such as increasing our efforts to routinely assess the performance of our programs and rigorously review the outcomes when making funding determinations to providers, will ensure that state dollars will be spent supporting the best and most essential programs.

The Governor has also asked the agencies to look for ways to coordinate services as a means of increasing efficiency while providing better services. Through the Inter-Office Coordinating Council (IOCC), OASAS works closely with the Office of Mental Health (OMH) and the Office for People with Developmental Disabilities (OPWDD). The IOCC aims to eliminate barriers to accessing care and to improve coordination of services for people with disabilities, particularly those served across multiple agencies. Through integration and alignment of agency structures and functions the three mental hygiene agencies are able to improve outcomes for individuals and the families they serve. For example, through a Memorandum of Understanding, both OASAS and the Office of Mental Health have emphasized the importance of integrated or "whole-person" care for those with co-occurring mental health and substance use disorders. No

matter through which door people seek treatment—OMH or OASAS—they should receive care that incorporates both mental health and addiction screening, assessment, and counseling.

OASAS has long worked with partners to provide services and administers a comprehensive array of prevention, treatment, and recovery services for New Yorkers with a network of service providers, as well as others, to provide a system of care that is integrated and coordinated so that individuals receive comprehensive services that focus on successful outcomes. Providers utilize evidence-based, outcome-oriented programs focusing on such risk factors as family conflict, permissive attitudes towards alcohol and substance abuse, and lack of commitment to school, which research shows are predictive of adolescent problem behaviors like alcohol and substance abuse, delinquency, teen pregnancy, school drop-out, and violence. While reducing these risk factors, prevention programs also focus on nurturing healthy beliefs and clear standards within community and family, since combining both activities is crucial to reducing the prevalence of problem behaviors like alcohol and substance abuse.

There is no doubt that the times are challenging, but OASAS is fully committed to Governor Cuomo's forward-thinking plan to reduce our costs by ten percent, bring about necessary reforms and improve outcomes for New Yorkers. The status quo is not good enough, and we cannot afford it. OASAS will do its work grounded in the fiscal reality of the times in which we live, while remaining focused on our mission and commitment to continuing critical support services.

Thank you for the opportunity to testify, and I welcome your questions and comments.

MHA in NYS
Mental Health Association in New York State, Inc.
Glenn Liebman, CEO
Sylvia Lask, Board Chair

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Glenn Liebman, CEO
Mental Health Association in New York State, Inc.

Testimony to:

Assembly Ways and Means and Senate Finance Mental Hygiene Budget Hearing

March 2, 2011

Thank you very much for the opportunity to speak today. My name is Glenn Liebman and I am the CEO of the Mental Health Association in New York State (MHANYS). Our organization is comprised of 31 affiliates in 54 counties across New York State. We provide mental health services in many of those counties, but we also provide educational and training programs as well as advocacy. We are strongly vested in the positive transformation of New York's mental health system.

The Importance of Community Based Mental Health Services

These are hardly the best of times, and even when we were going through those best of times, mental health funding was not a priority area. Now that we are in a very difficult time, mental health is certainly not a priority area for funding.

Yet, we know that community mental health funding should be a vital funding area for several reasons. First of all community mental health spending is a good investment. For every dollar spent on community funding, the state is saving at a much greater ratio. The end result of a robust, healthy community care network results in individual recovery and productivity and full integration in the community. However, an under funded community service structure leaves gaping holes that lead to poor and more expensive outcomes including emergency room visits, hospitalizations and the criminal justice system.

Secondly, to make matters even worse, the economic crisis is a mental health crisis in New York and across the nation. The economy has torn families apart. Unemployment,

bankruptcies, foreclosures have all left an emotional toll that is equally as significant as the economic toll. People are seeking mental health services in record number. The increased capacity for mental heath services is burgeoning while the funding to pay for this system of care has decreased with no new money in site.

That said, we are appreciative that the Legislature, The Cuomo administration, the Division of Budget and the New York State Office of Mental Health have recognized the importance of community mental health and the support that has been provided, even in lean times, is greatly appreciated.

Reductions in Community Services

Even with all the support, the cuts to community services have a significant impact. The proposed cut to local assistance programs is $27 million, half of which is related specifically to making the 1.1% FMAP cut permanent. Many of these reductions, including the permanence of the 1.1% reduction, go to the core of our community based funding. They are the money for suicide prevention, for care coordination, for jail diversion programs, for links to housing supports, for geriatric mental health programs, some veterans mental health services, PROS programs, supported employment, supported education, cultural competence programs, community linkage services and so much more. To the credit of the New York State Office of Mental Health, they are not reducing spending specific to children, families and peer support.

We urge you to do what you can to help restore funding for some of these vital programs.

Recommendation:

Help to restore the $27 million that was cut in the local assistance budget for community mental health services.

Funding for Parents with Psychiatric Disabilities

A major priority of our organization both at the State and local level is the funding for parents with psychiatric disabilities. Over fifty percent of adults in the mental health system are parents, yet rarely is the focus of services geared to their roles as parents. Like everyone else who is a parent, they have certain daily responsibilities in their parental roles. This is even more difficult for parents with psychiatric disabilities that are struggling with their own illness and often times having to fight for visitation rights or may even face termination of their rights as parents.

The Legislature recognized that there was a need for funding for this often forgotten population and several years ago, there was $850,000 dedicated for this program. $550,000 was to be utilized for services and $300,000 for legal advocacy.

This past year our organization received the $550,000 for the services piece of the project. We were able to make great inroads with this population by providing over thirty agencies with the tools necessary to start parent programs and parent support groups while

developing tool kits that will help provide information to parents, their loved ones, providers and other stakeholders about trainings, services and community engagement. Unfortunately, that funding was eliminated from the budget this year.

This was one of those cuts that actually will cost the state money. By providing family support and services as this project was doing, there is a reduction in lengths of stay in the juvenile justice system and in foster care. There is an actual, real tangible savings associated with this project. For every dollar you cut, you are actually costing several dollars to the state. We urge you help in restoring this funding.

Recommendation:

Help restore the funding for the much needed Parents with Psychiatric Disabilities Project.

Medicaid Redesign Team and Carving Out of Mental Health Services

Like many of our other colleagues, we read with great interest the final recommendations of the Medicaid redesign team. The biggest issue that our entire community faced was the fear that mental health services would be taken over by large health care plans. These large plans have been able to work successfully in many cases in managing health care needs, but they have not worked consistently with the complex care needs of people with psychiatric disabilities including those with co-occurring addictions disorders and health care needs. In other states, where they have managed mental health care, the outcomes have not been successful.

We are very appreciative that the Mental Health Commissioner, Dr. Michael Hogan, introduced an alternative plan that would provide for specialty behavioral health care agencies to begin the coordination of care for people with psychiatric disabilities. We believe that these plans in conjunction with the innovative work of the Mental Health Association members and other community agencies as well as with State and Local Government can create more coordinated care than we have had in the past. We support this plan and like virtually everyone else in the mental health community, are very pleased that it made it to the final recommendations reflected in the Governor's proposed budget. We urge your support for this important proposal.

Recommendation:

Support the Medicaid Redesign Team Initiative that calls for the specialty behavioral health agencies to manage services for individuals with psychiatric disabilities on Medicaid.

Concerns about Medication Accessibility and Across the Board Medicaid Cuts

We do have a few concerns about the redesign team proposals around medication accessibility. The carve-out of mental health medications has long been an important protection for people with psychiatric disabilities. As new agents have been developed, the

outcomes for many people's lives have been enhanced. However, as with all medication, one size does not fit all. What works effectively for someone may not have any impact to another person. We need to continue access to the wide array of mental health medications. Obstructing access through prior authorization or fail first does not serve the best interest of the individual.

In addition, one of the other fears we have is that the Prescriber Prevails consumer protection would be lost for doctors. In another words, doctors would not be able to override decisions made by a Pharmacy Benefits Manager. Ultimately, the best protection an individual can have with their medication is to work with their doctor who can have the ability to have final say in consultation with the recipient about their drug regime. No Pharmacy Benefit Managers should stand in the way of the best patient care.

Recommendations:

Restore language that will insure the continued carve out of mental health medications from the Preferred Drug List

Reject recommendations that call for the elimination of Prescriber Prevails

The two percent Medicaid across the board cut is of great concern as well. As I said earlier, in recent years there has been no new funding for mental health services (including three years in a row of no COLA) while capacity has dramatically increased. To absorb another

possible cut will just continue to limit the care needed to keep an individual in the community instead of in a more expensive institutional setting.

Recommendation:

Help to restore the proposed 2% cut to Medicaid

Other Issues

The Mental Health Association in New York State is involved in many other issues that need funding and services. Among those significant issues are suicide prevention, mental health screenings, youth in transition, children's services, veterans' mental health, geriatric mental health, cultural competence, workforce development, supported employment, supported education and much more.

Of particular concern is the continued need for housing services. People with psychiatric disabilities need a place to live and the choices are very limited. The lack of housing has led to an increase in homelessness, jail and prison. We support our colleagues at the Association for Community Living who are calling for not for profit housing agencies to take over housing services at State Operated Community Residences. This will save the state money and provide more housing opportunities in the community.

The recent adult home decision was a significant victory for many New Yorkers living in adult homes. However, the recent stay in the decision means that the good work around

getting people out of adult homes and into independent housing has been put on hold. Even with a stay in the order, the state can still continue the funding of these projects and moving forward with this much needed reform.

Recommendations:

Continue to support the important work being done in these areas of mental health.

Support the Not for Profit Takeover of State Operated Community Residencies

Support the Continuation of the funding for support housing for adult home residents

Summary

We are appreciative of the legislative efforts over the years to help people with psychiatric disabilities live productively in the community through your support of community based mental health services. These services are the safety net for people.

With your leadership and your partnership with the Executive, we hope to be able to continue the funding that will help to strengthen mental health services and provide hope and support for the hundreds of thousands of New Yorkers with psychiatric disabilities.

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Association for Community Living

JOINT SENATE/ASSEMBY
MENTAL HYGIENE LEGISLATIVE HEARING ON THE 2011-2012 BUDGET

March 2, 2011

Thank you, Assemblyman Farrell and Senator DeFrancisco, for this opportunity to submit testimony. We would like to acknowledge the participation and interest of the Senate and Assembly committee members present and in particular Assembly Mental Health Committee Chair, Felix Ortiz and the Senate Mental Health and Developmental Disabilities Committee Chair, Senator McDonald.

ACL represents over 115 not-for-profit community mental health agencies across the state that provide an array of mental health services including over 20,000 housing units with a rehabilitation focus. Our members serve primarily consumers who are affected by severe and persistent mental illnesses, many of whom have co-occurring serious medical conditions, substance addictions and mental retardation. Our members' programs are primarily funded and regulated by the Office of Mental Health. They manage clients' housing, their money, their medications, linkage to other services, and they ensure that clients follow care and after care instructions from physicians and psychiatrists after appointments and hospitalizations.

Many of the clients that we serve are high users of Medicaid. Staff in licensed programs supervises 5 to 25 medications per person without nurses or med certification. That translates into one staff person supervising over a hundred medications at individual moments during the day as well as managing billing notes, staff notes, meal planning and preparation, housecleaning and working on rehab goals with clients. **There is often one person working at a time. The staff/client ratios were set over 25 years ago and have not changed despite the increasing needs and challenges of the people we serve, increased regulation and administrative responsibilities, and OMIG audits.** Providers are reimbursed

19.2% and 21.3% of low salaries for mandatory and discretionary fringe benefits, although these packages typically cost 30%. The lack of increases over time has resulted in efficiencies – a good thing – so that administrative costs are at of 8 – 13%.

We applaud the Governor's attempt to re-balance the Medicaid system. As the Governor pointed out, there were over 13% in statutory increases slated to go into effect this year, a circumstance that has been in effect for years. Many programs in the MH and other systems are cost-based, have automatic trends, are re-based and/or have rate appeal processes. Hence the inordinate run-up in Medicaid costs. Other programs have none of these and so it is our position that a re-balancing of Medicaid must include an exercise where every program type is looked at in its historical context so that increases or cuts can be assigned accordingly.

For example, our programs were not originally cost based – rather their revenue was determined by a budget that OMH developed in 1984 with slight differences for downstate providers. They have never gotten an automatic trend increase, have never been re-based and do not have a rate appeal process in place. Most importantly, costs to the state for these programs are naturally capitated because there are a specific number of beds – if the programs are 100% full the state knows exactly how much the program will cost and it cannot cost more. Since it is virtually impossible to be 100% full at all times, the state actually pays less than the full amount, and, in fact, if a provider manages to perform at better than 85% or 83% occupancy (depending on the type of program it is) the state expects them to give 50% of all earnings gained from billing for clients they served above the 85% and 83% marks back to the state. It's a very good deal for the state.

The 2% across the board cut that the MRT proposes does nothing to help re-balance costs related to Medicaid. No attention was paid to the funding circumstances of different program types. Our programs are 12 – 38% BEHIND inflation (see Appendices A and B) while others that have gotten statutory increases over the years are well ahead of inflation, in some cases 30% ahead. How is it fair to treat everyone the same? Our programs were cut 4.1% in the Governor's proposed budget that was unveiled on February 1st. We already "gave at the office" in February but we also gave when we went without any increase of any kind for many years. Our programs are not "soft" programs. Many of these programs are

highly regulated and take responsibility for all aspects of a client's care, they provide staff 24/7 and they must respond to medical and psychiatric crises on the spot.

They are very efficient and have relied more and more on technological advances to drive down administrative costs, a good thing, in order to ensure that scant resources go to client care. Staff that only need to be in their offices part time because they see clients in their homes share cubicles. There are no more efficiencies to be found.

Our services are cost effective. Often the alternatives to our services are hospitalizations, incarcerations, premature institutionalization in nursing homes, or homelessness. These are far more expensive and inhumane alternatives to housing and services.

Those who received regular, generous trends and adjustments should be looked at first before any cuts are taken against those who did not. I have attached charts that show where ACL member agencies' residential programs are in contrast to the CPI for both Supported Housing and Licensed Residential services. They are behind the CPI by 12% - 38%.

Another program type - Unlicensed Supported Housing (SH) – also cannot take a 2% cut. It is seriously underfunded now and needs an increase in the near future to remain viable. A Supported Hosing bed costs a mere $14,854 a year downstate, including in all 5 boroughs of NYC. This is meant to cover rent for client apartments, administration, 24/7 on-call, and staff to work with the clients on self-sustainability. ACL has determined that a minimum of $16,713 is needed in NYC (see Appendix D for county by county adequate rates.) When the program was first conceived in 1991, the staff/client ratio was 1-15. It is now 1-35, and growing, with needs of the clients increasing each year.

Privatize state services: The attached chart (Appendix C) shows the difference in staffing costs between a community based not-for-profit operated community residence and a state operated one. The state operated programs cost more than twice as much although the services are identical and the regulations followed are identical. Reimbursement to a Not for Profit by the state for Personal Services, including benefits, for a 12 bed residence is approximately $220,000 upstate, $270,000 on Long Island/Lower Hudson Valley, and $272,000 in New York City. The approximate Personal Services cost for a SOCR of 12 beds is

$507,000. The state should turnkey existing state operated community residences over to the not-for-profits. **The savings could reach over $35 million.**

Medicaid Redesign Proposals

We fully support Proposal #93 to the MRT's proposal to create Behavioral Health Organizations. However, we are concerned that a wholly separate system of government operated services will remain in place. Certainly, county operated programs should be included in this newly structured system, as should state operated if possible.

We are also concerned should the state take a one size fits all approach to the implementation of the proposal. It is very possible that what will work in NYC will not work in other parts of the state. In small counties, high users are easily identified and found. The answer may be simple as identifying the high users, working with local providers to set savings targets, and share some of those savings so that providers can continue to work with more challenging consumers. One of the problems in NY is that some MH community based services are so underfunded that it is difficult to meet the needs of more challenging consumers while some very well funded programs have not been expected to work with more challenging consumers. The imbalance exacerbates the problems.

In addition, we are concerned that the providers, particularly our Medicaid reimbursed residential providers, will get caught between the competing priorities of state, county and BHOs. These programs could be used as hospital diversion or hospital step-down, and they are often that now, but it is informal and the providers still have some say over the client mix. They would need far more resources than they have now if the system raised its expectations for all the beds.

Thank you.

SUMMARY OF ACL's BUDGET PRIORITIES:

- Do not impose the 2% across the board cuts to those mental health community based services that are behind inflation.

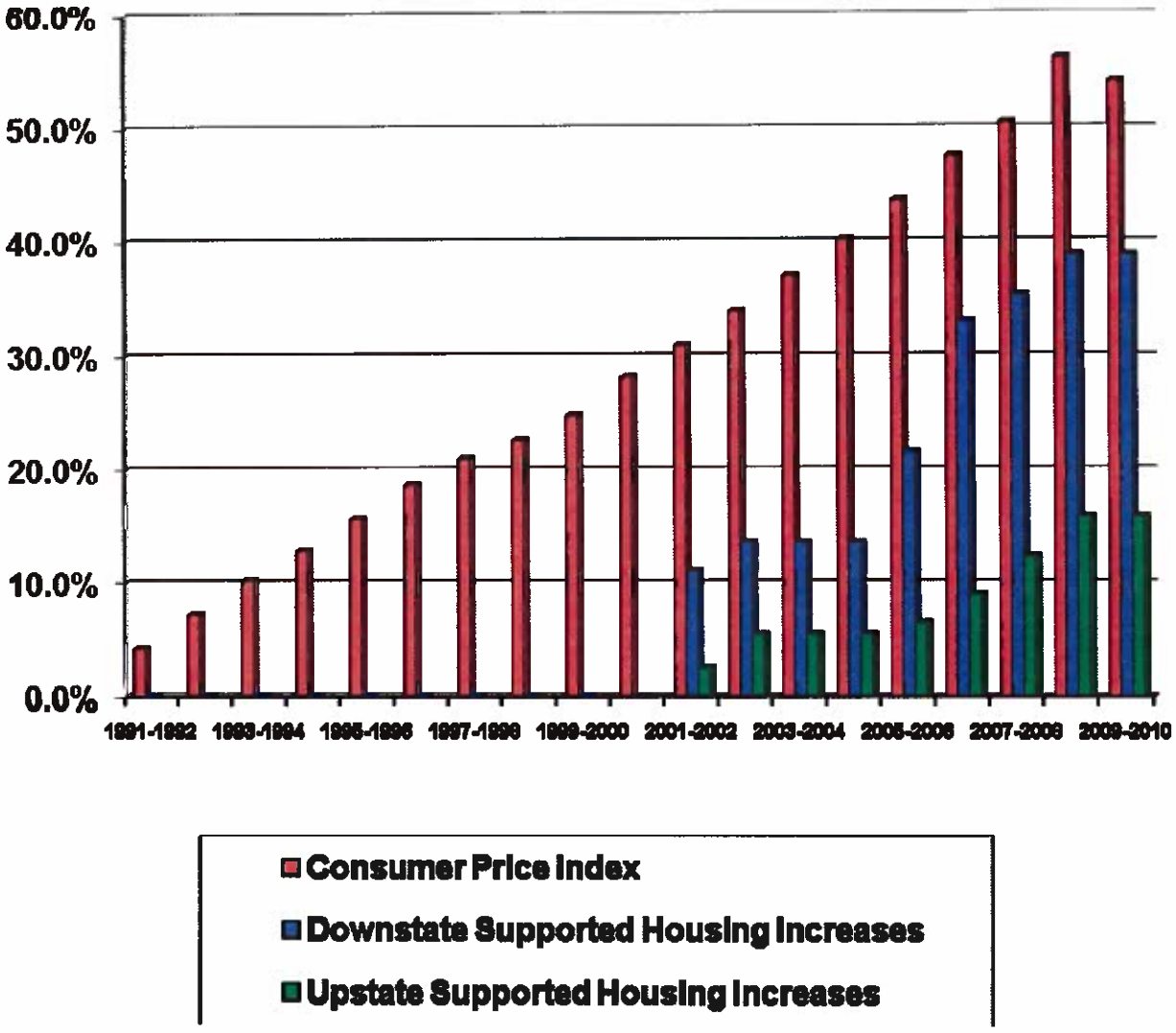
- Turn key State Operated community residences to not-for-profits and re-invest the savings into all community residences and Supported Housing

so that more challenging needs of consumers can be addressed and the viability of Supported Housing can be maintained.

- Support Proposal #93 of the MRT proposals with final language that does not lock the state into inflexible solutions that might not work in all parts of the state.
    - Include state and local government operated services in re-structuring,

APPENDIX A

SUPPORTED HOUSING – UNLICENSED
Cumulative Comparison
Consumer Price Index to Increases from 1991 – 2010



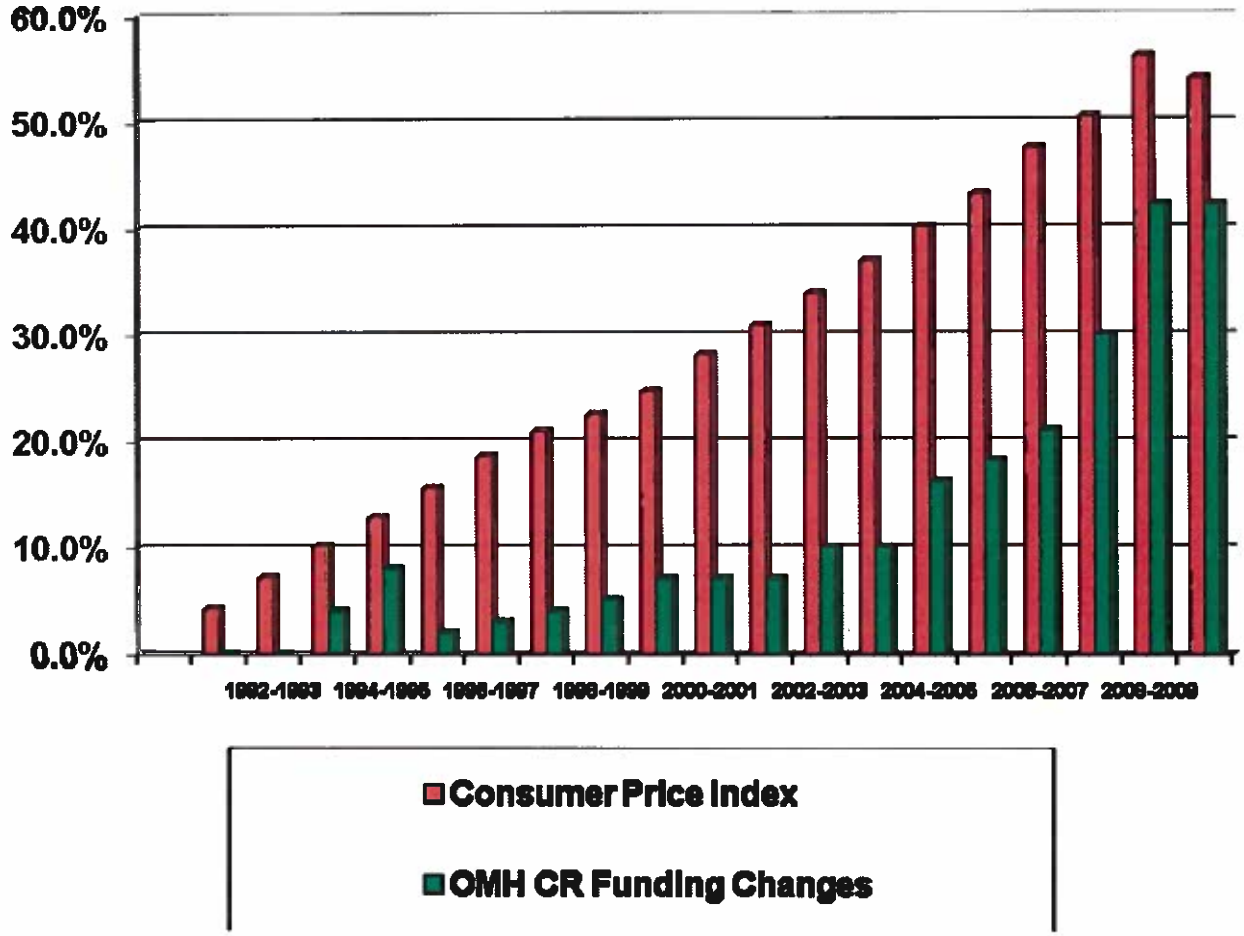
NOTE: Downstate includes: all of NYC; Nassau, Suffolk, Westchester, Putnam, Rockland, Dutchess, and Orange

APPENDIX B

Comparison of the Cumulative Consumer Price Index to the OMH CR Residential Funding

1991 to 2009

LACK OF INCREASES ARE NOT COUNTED AS CUTS



APPENDIX C

SALARY COMPARISIONS BETWEEN 2009 STATE OPERATED AND 2009 VOLUNTARY OPERATED 12 BED CONGREGATE RESIDENCES

State Operated				Upstate			Long Island		Lower Hudson NYC	
Position	**Grade**	**# of Staff**	**Salary $**	**Position**	**# of Staff**	**Salary $**	**# of Staff**	**Salary $**	**# of Staff**	**Salary $**
Residential Program Manager	17,19, 623, & 661	1	68,035*	Supervisor	1	31,204†	1	40,823†	1	41,082†
Residential Program Counselor	16	1	55,581*	Senior Counselor	1	30,543†	1	40,763†	1	41,024†
Residential Program Assistant	13	1	47,898*	None Comparable	0		0		0	
Residential Aides	9	4.56	39,530*	Residential Counselor	5.1	24,148†	5.1	27,597†	5.1	27,864†
Sub-Total without fringe		**7.56**	**347,210**	**Sub-Total without fringe**	**7.1**	**184,902**	**7.1**	**222,330**	**7.1**	**224,212**
		% of salary			**% of salary**		**% of salary**		**% of salary**	
Fringe Benefits		Approx. 46%±	159,717		19%†	35,131	21.3%†	47,356	21.3%†	47,757
TOTAL			***506,927***			***220,033***		***269,6860***		***271,969***

*2009 ACTUAL AVERAGE SALARY obtained through a FOIL request of the NYS Comptroller's office. It can be assumed that the overall actual salaries are higher in 2010 as a result of COLAs, and so these differences are conservative.

± STATE FRINGE RATE is from the New York State Office of Mental Health Fact Sheet – State Operations – 2008-2009 Executive Budget Recommendation Highlights.

†VOLUNTARY AGENCY REIMBURSEMENT RATE FOR 2009. Actual state salaries are compared to the reimbursement rate for the voluntaries because they are both reflective of what the **state** pays in each case.

APPENDIX D OMH Funded Supported Housing - STUDIO APARTMENT

The Following Chart Computes an Adequate, Cost Based Funding Rate for each county

This chart was first compiled in 2002. Each year it is updated with new HUD FMR and SSI, as well as OMH increases to the actual rate.

A. **RENT**: Based on HUD Fiscal-Year 2011 Fair Year Market Rents for a **Studio apartment**

B. **RENT PAID BY RESIDENTS**: Residents pay 30% of income, typically the SSI living alone rate of $761/month, which is $228 per month or $2,736 per year.

C. **TOTAL PROPERTY COST TO AGENCY**: Column A minus column B.

D. **CONTINGENCY FUNDING**: Based on current OMH minimum of $500 per recipient annually made available to resolve housing situations that put the resident at risk of losing his/her housing including non-collectable rent payments due to various reasons, minor maintenance not the responsibility of the landlord, furniture storage, and any other housing related emergency problems that, if not addressed, could cause loss of housing. This number has not changed since 1991.

E. **OTHER THAN PERSONAL SERVICES (OTPS)**: Based upon a realistic estimate that includes travel, insurance, office supplies, telephone, etc. Three estimates have been made for OTPS; $1,000 is used for urban/metropolitan counties, $1,200 is used for urban/suburban counties, and $1,500 is used for rural counties. The different rates reflect the amount and cost for travel that is required (Public transportation is less expensive and more accessible in urban areas; greater travel distances are required in the more rural counties.) This number has not been changed since 2002.

F. **CASE MANAGER**: The salary in this formula for a supported housing case manager for a caseload of 15 (standard set in NYS-SH guidelines) is $25,000. An additional 15% was added to the base salaries in New York City, Long Island, Westchester county and Rockland county. The rate includes 30% for fringe benefits.

G. **SUPERVISOR**: The salary in this formula for a supported housing supervisor for a caseload of 75 consumers/ 5 case managers is set at $38,000. An additional 15% was added to the base salaries in New York City, Long Island, Westchester County, and Rockland County. The rate includes 30% for fringe benefits.

H. **ADMINISTRATION and OVERHEAD (A&OH)**; at 15% on columns D through G (property is excluded.)

I. **ADEQUATE SUPPORTED HOUSING RATE**: Total of cost columns C-H.

J. **CURRENT SUPPORTED HOUSING RATE**: This is the rate SOMH pays by region for each supported housing unit in each county as of January, 2009. This rate remained the same for 2010 and 2011.

K. **SHORTFALL**: This number is the difference between column I and column J: per bed.

L. **NUMBER OF SH BEDS:** The actual number of beds in each county

M. **TOTAL COUNTY SHORTFALL**: The shortfall per bed (Column K) multiplied by the number of beds in the county (Column L) equals the actual shortfall in dollars specific to each county.

	HUD FAIR MARKET RENT	RENT PAID BY RESIDENTS	TOTAL PROPERTY COST TO AGENCY	CONTINGENCY FUNDING	O.T.P.S.	CASE MANAGER	SUPERVISOR	A&OH at 15%	ADEQUATE SUPPORTED HOUSING RATE	CURRENT SUPPORTED HOUSING RATE	SHORTFALL	NUMBER OF S.H. BEDS	TOTAL COUNTY SHORTFALL
	A	- B	= C	+ D	+ E	+ F	+ G	+ H	= I	- J	= K	x L	= M
ALBANY	8532	2740	5792	500	1,200	2190	659	682	11,023	9388	1,635	222	363,048
ALLEGANY	6816	2740	4076	500	1,500	2167	659	724	9,626	8520	1,106	32	35,389
BRONX	13,992	2740	11252	500	1,000	2492	757	712	16,713	14654	2,059	2365	4,870,363
BROOME	7152	2740	4412	500	1,200	2167	659	679	9,617	7760	1,857	143	265,537
CATTARAUGUS	6924	2740	4184	500	1,500	2167	659	724	9,734	8520	1,214	99	120,176
CAYUGA	7428	2740	4688	500	1,500	2167	659	724	10,238	7760	2,478	58	143,718
CHAUTAUQUA	7008	2740	4268	500	1,200	2167	659	679	9,473	8520	953	70	66,703
CHEMUNG	7836	2740	5096	500	1,200	2167	659	679	10,301	8520	1,781	93	165,624
CHENANGO	6972	2740	4232	500	1,500	2167	659	724	9,782	7760	2,022	53	107,161
CLINTON	7872	2740	5132	500	1,500	2167	659	724	10,682	7760	2,922	48	140,251
COLUMBIA	8592	2740	5852	500	1,500	2167	659	724	11,402	9388	2,014	36	72,500
CORTLAND	7500	2740	4760	500	1,500	2167	659	724	10,310	7760	2,550	50	127,495
DELAWARE	7056	2740	4316	500	1,500	2167	659	724	9,866	7760	2,106	27	56,859
DUTCHESS	9636	2740	6896	500	1,200	2167	659	679	12,101	13026	-925	202	-186,870
ERIE	7236	2740	4496	500	1,200	2167	659	679	9,701	8520	1,181	844	996,680
ESSEX	7416	2740	4676	500	1,500	2167	659	724	10,226	7760	2,466	28	69,045
FRANKLIN	6792	2740	4052	500	1,500	2167	659	724	9,602	7760	1,842	37	68,150
FULTON	5820	2740	3080	500	1,500	2167	659	724	8,630	7760	870	26	22,617
GENESEE	8112	2740	5372	500	1,200	2167	659	679	10,577	8520	2,057	42	86,390
GREENE	7428	2740	4688	500	1,500	2167	659	724	10,238	9388	850	26	22,097
HAMILTON	7476	2740	4736	500	1,500	2167	659	724	10,286	7760	2,526	4	10,104
HERKIMER	7404	2740	4664	500	1,200	2167	659	679	9,869	7760	2,109	27	56,940
JEFFERSON	7728	2740	4988	500	1,500	2167	659	724	10,538	7760	2,778	50	138,895
KINGS	13992	2740	11252	500	1,000	2492	757	712	16,713	14654	2,059	2,230	4,592,351
LEWIS	6900	2740	4160	500	1,500	2167	659	724	9,710	7760	1,950	44	85,796
LIVINGSTON	7140	2740	4400	500	1,200	2167	659	679	9,605	8520	1,085	38	41,226
MADISON	7608	2740	4868	500	1,500	2167	659	724	10,418	7760	2,658	26	69,105
MONROE	7140	2740	4400	500	1,200	2167	659	679	9,605	8520	1,085	343	372,121
MONTGOMERY	6900	2740	4160	500	1,200	2167	659	679	9,365	7760	1,605	33	52,962
NASSAU	14616	2740	11876	500	1,200	2492	757	742	17,567	14654	2,913	878	2,557,921
NEW YORK	13992	2740	11252	500	1,000	2492	757	712	16,713	14654	2,059	2458	5,061,882
NIAGARA	7236	2740	4496	500	1,200	2167	659	679	9,701	8520	1,181	121	142,889
ONEIDA	7404	2740	4664	500	1,200	2167	659	679	9,869	7760	2,109	217	457,631
ONONDAGA	7608	2740	4868	500	1,200	2167	659	679	10,073	7760	2,313	271	626,796
ONTARIO	7140	2740	4400	500	1,200	2167	659	679	9,605	8520	1,085	66	71,603
ORANGE	9636	2740	6896	500	1,200	2167	659	679	12,101	13026	-925	205	-189,646
ORLEANS	7140	2740	4400	500	1,200	2167	659	679	9,605	8520	1,085	25	27,123
OSWEGO	7608	2740	4868	500	1,500	2167	659	724	10,418	7760	2,658	48	127,579
OTSEGO	7308	2740	4568	500	1,500	2167	659	724	10,118	7760	2,358	38	89,600
PUTNAM	13992	2740	11252	500	1,200	2167	659	679	16,457	13026	3,431	53	181,838
QUEENS	13992	2740	11252	500	1,000	2492	757	712	16,713	14654	2,059	1259	2,592,722
RENSSELAER	8532	2740	5792	500	1,200	2167	659	679	10,997	9388	1,609	98	157,672
RICHMOND	13992	2740	11252	500	1,000	2167	757	664	16,340	14654	1,686	383	645,585
ROCKLAND	13992	2740	11252	500	1,200	2492	757	742	16,943	13026	3,917	160	626,776
SARATOGA	8532	2740	5792	500	1,200	2167	659	679	10,997	9388	1,609	44	70,792
SCHENECTADY	8532	2740	5792	500	1,200	2167	659	679	10,997	9388	1,609	119	191,459
SCHOHARIE	8532	2740	5792	500	1,200	2167	659	679	10,997	9388	1,609	21	33,787
SCHUYLER	7524	2740	4784	500	1,500	2167	659	724	10,334	8520	1,814	2	3,628
SENECA	7968	2740	5228	500	1,500	2167	659	724	10,778	8520	2,258	33	74,511
ST.LAWRENCE	6900	2740	4160	500	1,500	2167	659	724	9,710	7760	1,950	73	142,343
STEUBEN	7344	2740	4604	500	1,500	2167	659	724	10,154	8520	1,634	99	161,756
SUFFOLK	14616	2740	11876	500	1,200	2492	757	742	17,567	14654	2,913	1206	3,513,500
SULLIVAN	7584	2740	4844	500	1,500	2167	659	724	10,394	9388	1,006	41	41,242
TIOGA	7152	2740	4412	500	1,200	2167	659	679	9,617	8520	1,097	22	24,132
TOMPKINS	9468	2740	6728	500	1,500	2167	659	724	12,278	8520	3,758	54	202,927
ULSTER	9168	2740	6428	500	1,200	2167	659	679	11,633	9388	2,245	126	282,857
WARREN	7440	2740	4700	500	1,200	2167	659	679	9,905	9388	517	5	2,585
WASHINGTON	7440	2740	4700	500	1,200	2167	659	679	9,905	9388	517	43	22,227
WAYNE	7140	2740	4400	500	1,200	2167	659	679	9,605	8520	1,085	56	60,754
WESTCHESTER	13500	2740	10760	500	1,200	2492	757	742	16,451	14654	1,797	797	1,432,488
WYOMING	7128	2740	4388	500	1,500	2167	659	724	9,938	8520	1,418	20	28,358
YATES	7332	2740	4592	500	1,500	2167	659	724	10,142	8520	1,622	10	16,219
TOTAL												16,347	32,515,967

Jan. 2011 SUPPORTED HOUSING SHORTFALLS BY COUNTY – STUDIO APARTMENT

Testimony of Theresa Laws
Direct Support Professional, ARC of Rensselaer County
Member, Direct Support Professional Alliance of New York State

Before the March 2, 2011 Joint Legislative Public Hearing
On the 2011-2012 Executive Budget Proposal

Chairmen DeFrancisco, McDonald, Farrell and Ortiz; members of the Senate Finance and Mental Health and Developmental Disabilities Committees; and members of the Assembly Ways and Means and Mental Health Committees; thank you for this opportunity to provide testimony on the proposed Executive Budget for New York State as it relates to mental hygiene services.

My name is Theresa Laws. I am a Direct Support Professional with the ARC of Rensselaer County which supports more than 700 individuals with developmental disabilities and their families. I work in one of our agency's 75 residential settings, supporting six people who live there and who, like tens of thousands of other New Yorkers with developmental disabilities, require assistance 24-hours a day, seven-days a week.

I am also a member of the Board of Directors of the Direct Support Professional Alliance of New York State, or DSPANYS as we call it. DSPANYS is the New York State Chapter of the National Alliance for Direct Support Professionals. We are dedicated to improving the quality of services for people with disabilities by promoting the profession of direct support, adherence to a national code of ethics, and competency-based training programs. It is on DSPANYS' behalf that I am here today.

DSPANYS realizes that New York State, like families everywhere, must take stock of its income and expenses, balance its checkbook and live within its means. That task, given the current economic situation, requires belt tightening and sacrifices; the proposed budget reflects that. As such, I am not here to describe the plight of underpaid direct support staff who often work two jobs to make ends meet, although that is still a reality made worse by this economic crisis. Nor am I here to advocate for salary increases, cost of living adjustments or trend factors which would improve our lot. I realize the budget situation is too bleak for that.

With most of the fat already trimmed from services through past cost savings efforts, I am here to implore that the budget isn't balanced on the backs of direct support professionals through lay-offs or salary reductions. I'm here to urge that you look closely at expenditures that do not directly support individuals with disabilities – such as:

- excessive salaries and compensation packages for agency executives and administrators;
- the high cost of maintaining brick and mortar structures that tend to segregate people with disabilities from their community - such as developmental centers;
- expensive yet duplicative administrative processes among agencies doing the same job but located just blocks or miles apart - such as training activities, personnel functions and other back-office tasks; and
- costly person-hours spent on mere paper-compliance activities.

I ask that you look at these expenditures with an eye toward reinvesting them wisely to ensure constancy in the lives of the people we support. Constancy, in these uncertain times, is a rare and precious commodity which should be held dear.

The budget proposes measures that will alter agencies' operations in many still unknown ways. In so doing, the value of direct support professionals will take on increased significance. We are the ones who will be there on the frontlines, supporting individuals with disabilities, everyday, 24 hours-a-day, no matter what changes may occur in the service delivery system. In addition to providing constancy in the lives of thousands of citizens, we will be the first to know what is working, and what is not, as changes impact the people we support. As quality is determined at the point of contact, and not in some office in Albany, we will be vanguard of quality assurance efforts.

In considering the proposed budget, therefore, it is critical that one keep in mind measures that will ensure the presence of a stable, committed and professional direct support workforce. As desirable as salary increases would be, we know they are not possible at this time. But there are other low cost steps that can be taken to ensure constancy in a professional direct support workforce - steps that are worth their weight in gold.

First is the training of direct support workers in a set of nationally recognized and validated Community Support Skill Standards. All individuals so trained would bring the same skills to the people they support whether they are working in Buffalo or Long Island, in State operated programs or in the voluntary sector. It would promote universal adherence to a set of person-centered support standards.

Second is the credentialing of individuals who demonstrate competency in the standards. Credentialing is more than a piece of paper. It demands proof of proficiency in meeting the standards. It also means adherence to the National Code of Ethics for Direct Support Professionals. Workers from the Adirondacks to the Finger Lakes, in State ops and voluntary programs, would be guided by the same code of conduct. Credentialing could also serve as the foundation for salary adjustments at that point in time when the fiscal picture allows for such.

New York State does not have to invent this training and credentialing program. It already exits and is offered through the National Alliance for Direct Support Professionals. Its minimal costs would be offset by savings achieved by the hundreds of agencies which currently operate a myriad of different staff training and development programs.

Finally, as a direct support professional and a single mother of three who struggles to make ends meet on my salary, I can speak first hand to the value of the Health Care Adjustment Program which was not included in this year's budget proposal. For staff members like me, the health benefits it affords often provide that extra incentive to continue serving the people we support as opposed to finding employment elsewhere in a more lucrative field. I would urge that this program be reinstated as a step in ensuring constancy in the direct support workforce.

In closing, let me say, direct support professionals are vital members of the family of New York. We support our most vulnerable brothers and sisters. Like all families, we know the importance of living within our means. And we recognize the challenges New York faces this year in its attempt to do so.

As you consider the proposed mental hygiene budget, we respectfully ask that you pay careful attention to identifying ways in which savings can be achieved in areas that do not directly support people with disabilities so that these monies can be reinvested in promoting constancy and quality in their lives.

Thank you.

c/o NYSACRA, New York State Association of Community and Residential Agencies
240 Washington Avenue Ext., Suite 501, Albany, NY 12203; 518-449-7551

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Testimony of

Carmen Collado, Director of Public Policy & Government Relations
The Jewish Board of Family & Children's Services

At the Joint Legislative Hearing of
Senate Mental Health and Developmental Disabilities Committee
Executive Budget 2011-2012 - Mental Hygiene

Hon. Roy J. McDonald, Chair
Hon. Greg Ball
Hon. John J. Bonacic
Hon. Thomas K. Duane
Hon. Kemp Hannon
Hon. Shirley L. Huntley
Hon. Jeffrey D. Klein
Hon. José Peralta
Hon. James L. Seward
Hon. Lee M. Zeldin

March 2, 2011

UJA Federation of New York

Good morning, my name is Carmen Collado. I am Director of Public Policy and Governmen tRelations at the Jewish Board of Family and Children's Services (JBFCS).

I would like to thank Senator McDonald for chairing this meeting and the entire Senate Mental Health and Developmental Disabilities Committee for holding this hearing and working to insure access to mental health services for New Yorkers in need.

Jewish Board of Family and Children's Services (JBFCS) shares your concern about meeting the health and behavioral health needs of the 25% of New Yorkers covered by Medicaid. JBFCS is a major provider of behavioral health services in the New York City area. Over 8000 people are in treatment with us today. 75% are on Medicaid. We are one of the largest Article 31 clinic providers, and half of our patients are 18 or under.

We have been closely following the deliberations and recommendations of the Governor's Medicaid Redesign Team and while we applaud the Team's commitment to preserving essential services while meeting the Governor's budget reduction goals. We are very aware of the complexity of the system being redesigned and are deeply concerned with the rapid shift to a managed health care system and we hope you share that concern.

The greatest challenge related to behavioral health care is mentally adults with "co-morbid" conditions who require frequent in-patient stays for their physical health crises. Experience says that this is where a true collaboration of behavioral and physical health care offers hope for better care and meaningful cost reduction. Children are not "over-users" of Medicaid, and their behavioral healthcare is a good example of the system managed care would create with many tiers of service and family inclusion.

For these reasons, we were pleased to see the Medicaid Redesign Team has recommended to slow down the transition to mandatory Medicaid managed care enrollment and introduce regional behavioral health care coordination organizations carved out of the physical health managed care system. We need care coordination that preserves the expertise New York has developed in treating people with serious mental illness and coordinates with physical health providers with the behavioral provider as either the primary caregiver or perhaps the "health home" of the adult or child in need..

We encourage you to support the team's overall recommendation on the Medicaid carve-out but to also know that the implementation must be carefully monitored.

A proposal of concern that is much further from resolution is the proposed utilization controls on the number of clinic visits allowed. Proposal #26 in the Medicaid Redesign packet would set thresholds for the number of visits per year for OASAS, OMH & OPWDD care, reducing reimbursement for services in mental health, substance abuse and developmental disabilities

after the number of visits exceed a cap, at 25% fee reduction at a first threshold and 50% after a second cap.

We believe the caps set are clearly arbitrary and unrelated to diagnoses and seriousness of the condition. Furthermore, not-for-profit agencies will be forced to close programs because the discounted rates will not be sufficient to cover the expense of needed care and that will create a crisis for the most ill people..

The savings projected under this proposal will not be effective if it results in a return to the post-deinstitutionalization era with people with serious mental illness overwhelming emergency rooms and homeless on the street again.

The current proposed lower and higher threshold levels of annual visits are

65 visits results in 25% rate reduction, 85 in 50% reduction for OASAS programs

30 and 50 for OMH programs

and 90 and 120 for OPWDD programs.

Years of effective practice have shown that high risk populations like severely emotionally disordered children, adults with serious and persistent mental illness, clients with multiple issues, assisted outpatient treatment (AOT) clients, and other complex cases require more than 30 visits per year. Furthermore, lifetime reductions in the expense of care achieved through early identification and treatment of mental illness in children would be impossible at these rates. In all cases, this is a clear example of sacrificing the long-term effectiveness of the mental health system for the sake of short term dollar savings. Behavioral health treatment simply cannot be rationed out on an annual basis.

We urge the Committee to help make sure the long term health of New Yorkers is not jeopardized for the sake of expedient budget cuts.

Thank you again for this opportunity to testify.

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Testimony Before the NYS Legislative Joint Fiscal Committees

Mental Hygiene Budget Hearing March 2, 2011

Presented by
Harvey Rosenthal Executive Director
New York Association of Psychiatric Rehabilitation Services

On Behalf of NYAPRS Members and
The NYAPRS Public Policy Committee
Co-Chairs: Ray Schwartz, Carla Rabinowitz

NYAPRS Board of Directors
President Douglas Hovey

The New York Association of Psychiatric Rehabilitation Services represents a statewide partnership of 40,000 New Yorkers who use and/or provide community mental health services who are dedicated to improving services and social conditions for people with psychiatric disabilities
www.nyaprs.org

I'd like to thank the chairs and members of the respective committees for this opportunity to present to you the concerns of the thousands of New Yorkers represented by the New York Association of Psychiatric Rehabilitation Services. NYAPRS is a unique statewide partnership of New Yorkers with psychiatric disabilities and the community mental health professionals who support them in over 100 community-based mental health agencies from every corner of the state.

I'm Harvey Rosenthal, NYAPRS Executive Director. The following testimony that I will present incorporates the direct input of many hundreds of NYAPRS members who gathered at local forums that were conducted this past fall and winter in localities across the state including Amityville, Binghamton, Buffalo, Carmel, New York City, Syracuse, Westport and White Plains.

You may have seen our members out in great evidence last February 15th. Throughout that day, the Capitol was filled with over 800 orange-hatted New Yorkers with psychiatric disabilities and the community mental health staff who support them came to urge their state legislators and Administration officials to advance policies promoting their recovery, rehabilitation and rights.

State mental health policy is a very personal matter for our NYAPRS community. Many of our members, our board members, our staff and I all share a common personal journey of recovery from a psychiatric disability. We believe this strengthens our ability to speak to you on behalf of the thousands of New Yorkers with psychiatric disabilities and their supporters that we represent.

Our community greets this year's Executive proposal with the following reactions and recommendations.

Support Regional Managed Behavioral Health Care Coordination Initiative

New Yorkers with mental health, substance use and medical conditions require more active, engaging and better coordinated care that both promotes their health and recovery and reduces costly and avoidable ER and hospital stays. While many of those visits are to treat medical conditions, a majority of these individuals are not well engaged by health plans and medical practitioners, preferring to 'come into care' offered by behavioral health services.

NYAPRS and 40 other statewide and regional behavioral health advocacy groups have successfully advocated with the Governor's Medicaid Redesign Team for behavioral health care to remain "carved out" from being turned over to health plan management and instead be put under a specialty form of managed care called 'behavioral health organizations' that are more experienced with our community and much more supportive of recovery and peer services. Under this proposal, BHOs will operate regionally for the next two years, improving the integration and coordination of behavioral health care and link it to needed healthcare, housing and local supports in ways that will also reduce avoidable inpatient costs. Eventually, this will evolve into a fully integrated managed behavioral and physical health design.

Recommendation: Support Regional Managed Behavioral Health Care Coordination Initiative

Deep Cuts to Community Mental Health Services

The 2011 Executive Budget proposal cuts $27 million from our community mental health services safety net, including direct hits on several Medicaid mental health programs like continuing day treatment and children's Clinic Plus programs.

Built into this is a continuation of last year's 1.1% across the board cuts for all community programs. This cut also includes a currently unspecified drop in state aid for local mental health services, details of which are to be determined locally. For the third year in a row, it withholds a previously promised cost of living increase for our hard working dedicated nonprofit community workforce.

The budget also imposes a systemic freeze on new housing programs, except for long overdue supported housing services for adult home residents. However, those units have themselves been put on hold due to a recent stay of a federal court's ruling requiring community placements for adult home residents with psychiatric disabilities (see below).

This is not the time to cut the community safety net on which some of our most vulnerable New Yorkers rely. We urge state legislators to restore these cuts and suggest several strategies below to redirect savings from state operated service reductions to maintain our commitment to "protect the safety net!"

Recommendation: Restore community mental health cuts with funds derived from state services reductions.

Close State Hospitals, Reinvest Portion of the Savings

The budget recommends a 10% cut to state operated mental health services. New York is particularly poised to take that reduction as we operate 27 state psychiatric hospitals, almost 7 times the national average (4) and 4 more than the next highest two states combined (Texas (12) and Virginia (11) per 2008 data available from NASMHPD (the National Association of State Mental Hygiene Program Directors (see attached).

Further, New York houses fewer individuals per campus than other similar states; e.g. 2008 NASMPHD data indicated that California housed 5,188 individuals in 5 hospitals, Ohio housed 5,926 in 7 facilities in contract to New York's housing 5,282 individuals in 27 facilities.

New York topped the nation in cost for state hospitals, coming in at $1.2 billion, totaling more than the combined total of other top states Pennsylvania (#3 at $511 million and New Jersey (#4 at $502 million).

We have 17 adult facilities, each of which was originally constructed to serve thousands of inpatients. Most currently house and serve only around 100 individuals.

In 1994, the legislature approved the Community Mental Health Reinvestment Act which authorized the closure of 5 state hospitals and redirected a portion of the savings into boosting community mental health services.

Recommendation: This is the time to do **another major round of Reinvestment-driven state hospital closures that will yield considerable savings to the state, while also maintaining if not strengthening the community services safety net** that will need to be firmly in place to accommodate former hospital patients and the increasing number of 'high needs high cost' Medicaid beneficiaries that are a big focus of Medicaid reform.

Privatize State Operated Community Residences

According to our friends at the Association for Community Living, the state can save significant dollars within the residential system of care for people with psychiatric disabilities in ways that can sustain that same system at current or higher levels of funding by turning State Operated Community Residences (SOCRs) over to much lower cost Not-for-Profits (NFPs).

The OMH funded residential system is vital to New York because it cares for people with multiple diagnoses who require more extensive levels of support, without which they would join the ranks of the highest users of Medicaid. Housing instability is almost always tied to mental and medical instability for groups with serious, complex needs and so, investments in adequate housing save lives and dollars for New York.

New York State has operated a two-tiered system for years, operating more costly state operated community residential programs at the same time it has developed a vital sector of community residences run effectively and affordably by nonprofits.

An ACL report indicates that the state could save approximately $35 million in personal services alone if it transferred the operation of the 1,546 state operated community to the private nonprofit sector. There would likely be additional savings in OTPS related to food and food preparation, linen service, cleaning, etc.

Recommendation: Privatize State Operated Community Residential Programs.

Maximize Peer Services

One of the most promising, effective and affordable innovations in modern mental health care are peer-run services, which are run by individuals with psychiatric disabilities who are trained to provide quality support and service to their peers. Peer-run services have been in development for the past three decades and recommended time and again in important national reports including the 2003 Presidential Mental Health Commissions and the 1999 Surgeon General's Report on Mental Health.

Peer run services are developing an impressive body of evidence around their capacity to help "high cost high needs" individuals with mental health and related conditions to improve their engagement and participation in treatment, health care outcomes and diminished use of avoidable and costly emergency and inpatient services.

Peer services are demonstrating a crucially important and timely role in helping New York's health care system address and succeed at engaging our most challenging "high cost high needs" Medicaid recipients. Further, they are a comparatively low cost approach that yields extraordinary returns: a peer wellness coach earning $37,500 annually can produce that much in averting avoidable ER and inpatient stays in less than a month!

Recommendations:

- **Peer operated services should, as has been the case for previous years, be exempt from local budget cuts.**
- **New York should follow the lead of 23 other states and establish Medicaid reimbursement for peer services;**

- **It should also require managed health and behavioral healthcare organizations to contractually include such peer services in their benefit packages.**

Housing Set-Asides Prioritized for People with Psychiatric Disabilities

A safe, affordable home is the number one concern of mental health recipients. And research has proven that housing with supports is a key to recovery. Unfortunately, mental health recipients are able to access only a small percentage of the units financed by New York State. In 2010, for example, despite set asides and favorable scoring advantages, only 16% of the 1,600 units developed with low income housing tax credits went to people with special needs.

Recommendation: New York should set aside at least 40% of all units developed with any form of state subsidy for low income and homeless people with psychiatric disabilities.

Provide Supported Housing for Adult Home Residents

A recent federal court ruling found New York State in violation of the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's Olmstead decision by unnecessarily segregating 4,300 adult home residents with psychiatric disabilities. The court determined that adult homes are "segregated institutional settings that impede integration in the community and foster learned helplessness."

While the state has appealed the ruling, this year's budget contains the funds to move a first round of this group into the community with the help of peer inreach and community supported housing. A judicial panel recently imposed a stay on the state's requirements to provide that housing until the appeal has been ruled on.

Recommendations: The state must not require a judge's ruling to bring justice to adult home residents with psychiatric disabilities. It should use the allocated funds to provide them just access community based mental health housing and supports that will also help them reduce their typical reliance on costlier Medicaid services.

Open Access, Increased Oversight for Medicaid Mental Health Medications

For tens of thousands of New Yorkers, a disruption in access to the appropriate psychiatric medication results in relapses that are costly in terms of both human suffering and avoidable emergency and inpatient care. A the same time, prescribing practices that don't use evidence based medications or that use too many drugs simultaneously (polypharmacy) are demonstrating harmful effects (e.g. frequent connections to metabolic syndrome, diabetes, etc) and costing too much.

NYAPRS continues to advocate for unrestricted access to such medications to protect patient choice and care and we oppose the proposal to eliminate fee-for-service reimbursement for pharmacy and their 'carve in' into managed care plans.

At the same time, we urge an expansion in programs like PSYCKES, which improves psychotropic prescribing practices by red-flagging costly and health-threatening use or overuse (too many for too long) of such powerful medications, as well as increased use of electronic prescribing best practices to reduce avoidable errors.

Recommendations:

- **New York should continue to promote unrestricted access to protected classes of medications like mental health drugs to protect patient choice and care by rejecting proposals to:**
  - **eliminate vital 'prescriber prevails' protections.**
  - **carve in pharmacy into Medicaid managed care plans.**
- **In order to improve the management of psychiatric prescription drugs and to avoid excessive Medicaid spending, the State should expand the PSYCKES quality improvement program to all community- and hospital-based mental health providers in New York State and further enhance electronic prescribing best practices that will reduce medication errors.**

Fully Fund Forensic Mental Health Initiatives

Too many people with psychiatric disabilities find their way into our jails and prisons—and the numbers appear to be growing. While we advocate for stronger community mental health services and preventive services which keep persons with psychiatric disabilities from ever penetrating the criminal justice system, we are compelled to be concerned for the plight of those among us who can easily be forgotten, locked away in the state correctional system suffering with symptoms.

Many people with mental illness are not able to comply with the rules in prison and are punished with placement in disciplinary confinement (know as Special Housing Units, or SHU), subjected to 23 hours of complete isolation, poor treatment, malnutrition, and increased risk of mental deterioration.

In 2008 with the enactment of the SHU Exclusion Law, New York State made a statement that it would no longer tolerate the noxious effects of long-term solitary confinement on persons with a mental illness. The law which goes into effect in July requires the state to provide appropriate mental health assessments, keep eligible individuals out of SHU, afford them structured out-of-cell therapy and treatment on a regular basis, and assist them toward a reasonable recovery.

For the promise of the law to be realized, the OMH budget must include adequate funding for prison mental health care, including the allocated addition of a 60-bed Residential Mental Health Unit at Five Points Correctional Facility in Se. Through appropriate assessment and treatment from the outset, many imprisoned people can avoid contact with the prison disciplinary system all together. For those who are charged with infractions, OMH must be fully capable of providing the treatment alternatives required by the law.

Recommendations: Support Full Funding For Prison Mental Health Reforms.

Year after year, state Legislators have been tremendous partners in our joint efforts to advance the recovery, rehabilitation and rights of New Yorkers with psychiatric disabilities. I would like to thank you for your extraordinary record of support and for your help going forward once again this year.

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Testimony

Of

Andrea Smyth
Executive Director
New York State Coalition for Children's Mental Health Services

Submitted to
The Joint Fiscal Committees of the NYS Legislature
The Honorable John DeFrancisco and The Honorable Herman Farrell
Chairmen

Wednesday, March 2, 2011

"We can't solve problems by using the same kind of thinking we used when we created them." – Albert Einstein

Thank you for this opportunity to testify about the Executive Budget recommendations for 2010-11 to the Joint Fiscal Committees of the New York State Legislature.

I am Andrea Smyth, the Executive Director of the NYS Coalition for Children's Mental Health Services, a statewide association of over 40 nonprofit children's mental health providers. We offer quality clinic, residential, home and community based waiver, family based treatment and family support services for children and their families in every county in New York.

Here is the item the Coalition opposes in the Governor's budget recommendation:

1. Elimination of the 370 bed Family Based Treatment program.

Here are the items the Coalition asks you to amend in the Governor's budget proposal:

1. Amend the Medicaid Redesign Team's recommendation to impose the same utilization limits on children's outpatient clinic services as those recommended for adults;
2. Amend the Governor's recommendation to notwithstand the Community Mental Health and Workforce Reinvestment Act to quantify any state savings generated through closure of child & youth inpatient beds for the next two state fiscal years and consider appropriating those funds to support expanded community-based children's mental health services in SFY 2013-14;
3. Amend the Governor's recommendation to convert the state child & adolescent inpatient beds at Brooklyn Children's into 100% state-operated community-based children's mental health services; and
4. Amend the Governor's recommendation regarding the creations of a Supervision and Treatment Services for Juveniles Program

Here is the item we ask the Legislature to support in the final budget agreement:

1. Utilization of a behavioral health organization to coordinate behavioral health care for those who qualify for Medicaid as recommended by the Medicaid Redesign Team.

<u>Regarding Reinvestment</u>

Last year, the Legislature extended the provisions of Community Mental Health and Workforce Reinvestment Act. However the state's fiscal situation has resulted in multi-year freezing of the reinvesting components of the Act. This year the Governor

proposes to authorize the Commissioner to close state operated inpatient psychiatric beds on two weeks notice to the Legislature, but makes no provision to review or reconcile community need with the loss of those services. As it pertains to children's beds and services, the Governor does propose reinvestment in the Office of Children and Families budget as it relates to reducing the number of child and adolescent state operated juvenile justice beds. I urge that you enact parity for child and adolescent mental health services. Honor community mental health reinvestment and the sound public policy that it represents. If the funds MUST be used for state fiscal relief this year, at least enact an accounting mandate of the amount of funding that should be captured for community mental health reinvestments and order a reconciliation take place in State Fiscal Year 2013-14.

And if you authorize the proposal to eliminate state operated inpatient services at Brooklyn Children's Hospital, please reconsider enacting 100% reinvestment into state-operated community services. The expansion of crisis residences is a key component of juvenile justice reform and hospitalization avoidance. Yet, state-operated children's crisis residences cost 30% more to operate. The Coalition urges the Legislature to enact the most efficient Reinvestment policy as possible and divide the reinvestment development 50% state operated and 50% nonprofit operated. We also urge consideration be given to creating a Children's Reinvestment Act so New York can finally begin developing blended funding for community service capacity for children and families leaving residential placements.

<u>Supporting the MRT Recommendation for Behavioral Health</u>

The Coalition is pleased that the Medicaid Redesign team recommendation is to use a behavioral health organization to better coordinate children's mental health services. We carefully point out that the majority of children currently exempt from Medicaid Managed Care enrollment will not be affected by the changes until Year 3 of the effort for 100% Medicaid Managed Care expansion. This is an important component of the recommendation to retain. Design and implementation of this new behavioral health care coordination component must take into account the huge number of children currently exempt from managed care and receiving their services in residential settings which are funded independently (foster care per diems for health care and OCFS state-operated JJ facilities building their own mental health treatment capacity). Here is a quick rundown on the additional demands that high-need children will place on community based providers:

- In 2002, there were nearly 30,000 children placed by New York City into residential foster care. In August 2010 the number of placements was just over 15,000, so those youth are in the community, with their families, seeking behavioral health care support from community providers;
- Last year the state closed 180 residential Juvenile Justice beds and in this budget, there is a recommendation to reduce the capacity by another 379 beds.

- Since 2005, the state has lost 198 non-secure detention beds (42% of capacity) and there are only 9-locked nonprofit detention facilities operating in the state.
- In addition, the budget proposes to eliminate 370 Family-based Treatment residential opportunities in the OMH budget, and
- Proposes to end state reimbursement for the few remaining secure and non-secure detention beds operated by non-profit agencies, and
- Proposes to increase the school district costs when Committees on Special Education order residential placement of troubled youth from school districts.

If enacted as proposed, by this time next year, there will thousands of more kids in the community needing behavioral health services, substance abuse services and intensive monitoring and supervision. And, there will be 370 fewer options if the FBT program is eliminated as proposed. So, the Coalition Supports the use of behavioral health organizations to coordinate children's behavioral health benefits, but urges the Legislature to support Year 3 implementation of mainstream managed care enrollment for the exempt children's categories because of the complexity of unraveling existing funding mechanisms and the need to build community capacity through vehicles such as, a Children's Reinvestment Act.

We also hope that the "Health Home" recommendation of the MRT, an effort to managed the highest cost, chronically ill Medicaid patients will incorporate a child and adolescent component. This Health Home option will allow New York to draw down enhanced federal Medicaid matching funds for the highest need Medicaid recipients in order to avoid hospitalizations and long-term chronic health problems that develop as a result of co-morbidities. The Adverse Childhood Experiences (ACEs) study has demonstrated that untreated mental health issue in children greatly increase chances of adults developing hypertension, heart disease, diabetes and other debilitating health conditions. It is a proven study of how the body manifests the debilitating conditions of the mind. We strongly urge that a children's behavioral Health Home program be included under the MRT "health home" implementation.

Regarding Elimination of the Family Based Treatment Program

Demand for crisis and community-based children's mental health services is rising and this budget is reducing children's mental health resources. We are opposed to the proposal to eliminate the FBT program. Not only do the majority of children placed out of their home into FBT, get discharged to home or to a lower level of care, 58% of the children served by this program in 2010 were between 13 to 17 year olds. This age cohort is among the most difficult to serve and most commonly requires out-of-home care. Short term out of home care IS a crucial component of alternatives to detention.

More importantly, FBT programs can be used by other programs in the community for short term respite and crisis stays to stabilize children and family situations and avoid hospitalizations and or referrals to the child welfare or juvenile justice system. It is exactly the type of program that must be available if we are going to successfully reduce the number of detention placements and avoid expensive Medicaid hospitalizations for children and adolescents that need mental health services. FBT costs about $162 per day, whereas as stay in a state-operated child and adolescent psychiatric bed costs between $900 and $1,200 per day. Do not eliminate an effective, efficient children's mental health service option just as demand for children's behavioral health services is exploding.

Strengthen the Governor's proposed Supervision and Treatment Program

In the OCFS budget recommendation, the Governor attempts to shift spending from residential juvenile justice placement into community based treatment spending. The Coalition supports the philosophy, but does not believe the Governor's recommendation gets the funding adjustments 100% correct.

First, the Coalition does not support the elimination of the 49% state match on residential secure and non-secure placements. This cost shift to counties will just weaken the quality of mental health care and treatment offered to juvenile offenders while in placement. However, the Coalition does approve of more carefully shifting funding from out-of-home placements into community services, such as those proposed through the Supervision and Treatment Program. Between the $31.7 million recommended funding for the new Supervision and Treatment Program and the proposed $53 million for secure and non-secure throughout the state fiscal year, we believe there is enough funding to better blend a transition toward the community based Supervision and Treatment program, taking the actual vacancy rates as they occur and permanently exchanging that residential funding into community funding. The transition proposed by the Governor burdens the counties twice with higher match for residential and a match for community services. A better transition will guarantee success.

An important caution, working with this population of children and their families is extremely challenging. Here are the words of the CEO of Children's Village, a member agency that has had tremendous success with children in their Alternatives to Detention Program:

There are those who claim that the children incarcerated in these distant facilities are all graffiti artists or turnstile jumpers. This, unfortunately, is a disingenuous oversimplification. The truth is that some have committed serious crimes, but that's only part of the story. About 30 percent of these children are in dire need of mental-health services. Most are children of color, and they come from our poorest neighborhoods, failing schools, and highly

stressed family situations. They lack the appropriate role models crucial to a child's development. It is time to be honest about the issue.

The truth is that without access to short-term out-of-home crisis, respite and temporary services for this population, no transition plans will be successfully implemented. One of the key components of the Children's Village success was the ability to arrange 21-day out-of-home stays at a community residence while some adolescents and their families underwent Multi-systemic therapy (MST) an evidenced based clinical counseling program that has incredible success rates nationwide. Funding for that 8 bed community residence was lost because of last year's 6% across the board cut. I raise this because the tools necessary to successfully bring about juvenile justice reform or state psychiatric downsizing must include funds for short-term out of home stays. Yet beds are being lost to the child caring system because "community services" are the buzz word. As Children's Village implores, "Let's be honest about the issue." Create a Children's Reinvestment Act so children's mental health and a continuum of necessary service options are funded.

We also recommend that the right providers have access to the Supervision and Treatment funds and have itemized the following as possible eligibility criteria:

- Access to crisis and respite beds for short-term out-of-home placements
- Access to Family Support Advocates and at least 2 years experience with integrating Family Support Services into treatment plances
- At least 2 years experience with transition planning for youth leaving any OASAS, OMH, OCFS, DCJS or SED residential placements
- At least 2 years experience with the provision of children's mental health services
- At least 5 years experience with OCFS preventive services

Thank you for this opportunity to testify.

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March 2, 2011

The Health Care Reform Tracking Project:
Comparing Behavioral Health Care Provided Through Carve-out and Integrated Systems of Care

The Health Care Reform Tracking Project* is the ***only national study to focus specifically on the impact of public sector managed care systems on children and adolescents with behavioral health disorders*** and their families. It was conducted in all 50 states and the District of Columbia in 2003. The project included 39 managed care systems in 37 states, 22 carve-outs, and 17 integrated physical health/behavioral health managed care systems.

Findings:

- Carve-outs are significantly **more likely to involve all stakeholder groups** than are integrated systems.
- Carve-outs are **significantly more likely to cover the total Medicaid population** than are integrated systems (55% of carve outs versus 19% of integrated systems).
- Carve-outs are **more likely to provide education and training** regarding all special populations than are integrated systems; carve-outs are twice as likely to provide training about home and community-based services and about systems of care.

Better coverage of services with carve-outs:

- **More likely to cover a broader array of services.** Half of the carve-outs (50%) but only 18% of the integrated systems covered 80–100% of the mental health services included on the list in the survey.
- **More likely to cover most or all of the substance abuse services.** Nearly half of the carve-outs (48%) and 27% of the integrated systems covered most or all of the substance abuse service array listed.
- **More likely to report expanded availability of home and community-based services.** About 81% report carve-outs report some or significant expansion; none of the integrated systems report significant expansion; in nearly half of the integrated systems (44%), there has been no expansion at all.
- **Improved access to extended care** (in comparison with pre-managed care). Access has improved in 71% of carve-outs but in less than half of the integrated systems (46%).

Better treatment with carve-outs:

- **More incentives for evidence-based practices.** Most carve-outs (77%) reportedly are encouraging or providing incentives for providers to use evidence-based practices, but fewer than half of the integrated systems (44%) are.
- **Improved coordination between mental health and substance abuse services** is more evident in carve-outs (73%) than in integrated systems (46%).
- **More support for local systems of care.** The majority of carve-outs (90%) but less than half of the integrated systems (44%) facilitate and support the development and operation of

local systems of care for children with serious behavioral health disorders, including principles of broad service array, family involvement, individualized services, care management, and cultural competence.

Better use of resource dollars:

- **Significantly more likely to use multiple types of funding contributed by multiple agencies.** Carve-outs are more likely to use state general revenue, block grants, and child welfare dollars, in addition to Medicaid, as opposed to integrated systems, who are more likely to use SCHIP and TANF dollars, in addition to Medicaid.

- **More likely to incorporate strategies to clarify responsibilities for providing and paying for services across child-serving agencies than are integrated systems.**

- **Less to use capitation than integrated systems** (68% of carve-outs versus 93% of integrated systems).

- **More likely to place limit on MCO administrative costs** (71% of carve-outs versus 42% of integrated systems); in addition, 57% of carve-outs limit MCO profits, versus 17% of integrated systems.

- **Greater success in reaching cost containment, access, and quality goals.** About 73% of carve-outs are in the moderate or mostly successful category in achieving goals such as containing costs, increasing access, expanding service array, improving quality, and improving accountability compared to 56% of the integrated systems.

Better cultural competency:

- Carve-outs employ a greater extent of cultural competence strategies than integrated systems, including outreach to culturally diverse populations and training of MCOs and providers on cultural competence.

Greater involvement of families:

- **More likely to involve families at system and service delivery levels.** Most carve-outs (62-86% in 2003) reportedly include various strategies to involve families at the system and service delivery levels in managed care systems. In contrast, nearly half of the integrated systems do not incorporate any of these strategies for family involvement.

- **Greater focus on service for families as well as identified child.** About 79% of carve-outs focus service delivery on the family in addition to the identified child versus only half of the integrated systems. Carve-outs are also more likely to cover both family support services and pay for services to family members if the child is covered.

- **More likely to measure both parent and youth satisfaction.**

* The Health Care Reform Tracking Project was conducted jointly by the Research and Training Center for Children's Mental Health at the Louis de la Parte Florida Mental Health Institute (FMHI), University of South Florida; the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development; and the Human Service Collaborative of Washington, D.C., in 2003. For the full study, please go to http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/2003_statesurvey/index.htm.

NEW YORK STATE SENATE FINANCE
AND
ASSEMBLY WAYS AND MEANS COMMITTEES
MENTAL HYGIENE BUDGET HEARING

WEDNESDAY, MARCH 2, 2011

TESTIMONY BY:
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Good Morning. My name is John Coppola. I am the Executive Director of the New York Association of Alcoholism and Substance Abuse Providers, Inc. (ASAP). We are the statewide association that represents the interests of chemical dependence and problem gambling treatment, prevention, and recovery programs from throughout New York State. Included in our membership are more than 200 agencies that provide a comprehensive continuum of services, twenty statewide and regional coalitions of programs, and a number of affiliate and individual members.

Our membership is committed to working with Governor Cuomo, the Senate, and the Assembly to ensure the responsible stewardship of valuable resources and the provision of excellent quality services that improve the health and quality of life for individuals, families, and communities throughout New York State. Chemical dependence and problem gambling treatment, prevention, and recovery support programs are an invaluable resource to state and local governments looking to address the needs of their communities in a budget environment that requires provision of cost-effective services that produce the desired results.

ASAP understands that these are very difficult economic times and that New York State has a significant deficit that must be remedied with a combination of reduced expenditures and increased revenue. The Executive Budget proposal recognizes the need to bring state spending into line, to streamline government as a way to improve efficiency and to institute policies that pay for program outcomes. We understand and support the Governor's insistence that state resources should only be used to support services that produce the desired end results. As we have testified in previous years, the deficit can be reduced by spending wisely on programs that create savings and achieve desired results. Investing in treatment, prevention, and recovery creates savings for NYS. Successful chemical dependence and problem gambling outcomes mean less spending for healthcare, criminal justice, public assistance, child welfare, domestic violence services, and many other needs that occur when addiction goes untreated.

We would like to recognize the work done by the Medicaid Redesign team to identify ways to bring New York's Medicaid expenditures into line while improving outcomes and quality care. We appreciate that several of ASAP's recommendations, which I will review in some detail here today, were included in the recommendation package adopted by the team and accepted by the Governor last week. We strongly encourage the Senate and Assembly to work with us to ensure that these recommendations are implemented in a responsible and thoughtful way that avoids any potentially harmful impact on service delivery and access.

Carve-out Behavioral Health Services

Regarding Medicaid redesign proposals included in the Executive Budget, ASAP strongly recommends that, if substance use disorders treatment is to be managed, care management should be administered by a behavioral health managed care organization under the regulations of, and with oversight by, OASAS. Services should not be 'carved-in' to the management of broader health benefits. ASAP also strongly recommends that all licensed OASAS treatment programs should have guaranteed access to managed care service provider panels. Without this mandate, the treatment infrastructure could crumble.

Reform Detoxification Services.

Unnecessary hospital admissions have been identified by the Medicaid Redesign Team as one of the primary reasons New York State's Medicaid program is underperforming and overspending. Persons with substance use disorders are one group of healthcare consumers that have been identified as being disproportionately represented among those who are unnecessarily admitted to hospitals for care. Untreated addiction is a common variable in close to 80% of the unnecessary hospital admissions in NYS. Of particular concern are persons who receive detoxification services that are not connected to an appropriate level of care for their substance use disorders and are repeatedly readmitted to the hospital for subsequent detoxification and other costly medical services.

Recommendation: Service delivery should be redesigned as outlined in the Joint Task Force on the Continuum of Care for Alcoholism and Substance Abuse Services' 2008 report. Central to our redesign proposal is the fact that persons experiencing an uncomplicated opioid withdrawal, which is rarely life threatening, can be treated safely and effectively in a community-based clinic. We propose a redesign of service delivery that significantly increases the use of medication assisted (i.e. methadone, suboxone, vivatrol, etc.) outpatient treatment for substance use disorders, especially for persons with an addiction to opiates, instead of repeated hospitalizations for detoxification that does not lead to engagement in treatment and a process of recovery. We further propose service redesign that increases use of community-based inpatient/residential and outpatient detox as an alternative to hospital-based services where it is a clinically indicated alternative.

Savings: NYS will save approximately $12.5 million if 20% of the medically managed and 20% of the medically supervised detoxifications for opioid dependence shift from hospitals to medication assisted treatment in community settings and if 10% of persons currently receiving medically supervised detoxification in hospitals are shifted to outpatient settings.

Utilize Case Management and the Managed Addiction Treatment Services Program to Drive Down Medicaid Expenses.

Targeted case management has proven to be effective in helping patients access the proper level of care and in reducing unnecessary use of expensive hospital services. Most notably, patients with substance use disorders who repeatedly utilize emergency departments or hospital-based detoxification without achieving the desired outcomes of connecting to an appropriate level of care in a treatment program and attaining a sustained period of recovery are among the most costly Medicaid services consumers in NYS. New York City has saved close to $10 million in each of the past three years by providing case management services to only 750 of the 4500 individuals who utilize $30,000 or more annually just for substance use disorders related services (predominantly multiple admissions for hospital detox). Case management, managed by OASAS, guided by strict standards (regarding patient admission criteria, establishment of medical necessity, and utilization review), utilizing science-based tools for level of care determination and evidence based treatment protocols will help eliminate waste and improve care and patient outcomes statewide.

Recommendation: Utilize case management and expand the Managed Addiction Treatment Services (MATS) program to every county in NYS and increase the MATS caseload in NYC. ASAP recommends that the MATS case management caseload in NYC should be tripled to 2250 of the 4500 persons who utilize more than $30,000 annually in SUD related services alone. We also recommend that an equal number of persons outside of NYC should receive case management services.
Savings: $20 million in new savings will be generated in NYC if the caseload is raised to 2250 and an additional $30 million can be saved if 2250 persons are served outside of NYC.

Screening, Brief Intervention and Referral to Treatment Can Reduce Medicaid Costs.
Decisive action must be taken to decrease the levels of improperly treated or untreated addiction that drive up hospital re-admissions and unnecessary use of emergency departments. The substance use disorder underlying the need for recurring medical care often goes undetected in hospitals and in physician practices. Failure to identify substance use disorders leads to unnecessary hospitalizations and other expensive medical care.
Recommendation: Make screening, brief intervention, and referral to treatment (SBIRT) for alcohol and drug problems a routine part of every primary care and emergency room visit. (In a recent University of Texas Southwestern study, Larry Gentilello, Professor of Surgery, estimated that hospitals save $3.81 for every dollar spent on brief counseling of ER patients.)
Savings: If 100 NYS hospitals implement SBIRT and screen all hospital admissions, NYS can save $42.15 million. This savings is based on hospitals utilizing only one or two staff people to conduct the screening and brief intervention and make a referral to the proper substance use disorder treatment program.

Substance use disorders prevention, treatment, and recovery services are a critical partner for those charged with redesigning New York States Medicaid program. We stand ready to do the work necessary to improve health outcomes in an environment where cost containment and reduction are a paramount concern. We have several other recommendations that we ask the legislature to consider as the 2011-2012 budget is developed, which support the notion that prevention, treatment and recovery is an investment which ultimately saves money for New York while vastly improving quality of life.

Preserve Problem Gambling Prevention Services. NYS is currently expanding the availability of gambling, increasing the risk for problem gambling and its consequences. Funding for problem gambling prevention and treatment programs should not be cut at a time of increased risk. Approximately one million New Yorkers currently have a gambling problem. In 2010-2011, NYS *sponsored* gambling generated approximately $3.1 billion in revenue for New York. Little was budgeted for research, prevention, treatment and education services focused on problem gambling. In 2011-2012 the proposed budgeted amount for research, prevention and treatment of this problem is as little as $1 million. New York State is the *only* state in our nation without dedicated funding from gambling revenues for problem gambling services. ***ASAP recommends that one half of one percent of revenues generated by new gambling opportunities should be set aside to support a comprehensive continuum of problem gambling services.***

Reinvest Savings from the Closure of Juvenile Justice Facilities and Prisons. NYS is correctly shifting its policies to reflect the reality that addiction to alcohol and other drugs is a public health, not a criminal justice, problem. Substance use disorders prevention, treatment, and recovery programs are cost-effective and produce many desired outcomes for NYS communities. ASAP recommends that the NYS Senate and Assembly pass legislation reinvesting savings from the closure of under-utilized or poor performing juvenile justice facilities and prisons into community-based prevention, treatment, and recovery services. Without this reinvestment, NYS cannot achieve its reform goals. To ensure that there are

sufficient community-based services to compliment the closure of prisons and juvenile justice facilities, NYS must not make cuts at this time to prevention, treatment and recovery services.

Alcohol Harm Surcharge. The costs and consequences associated with problem drinking, most notably underage drinking, alcoholism, accidents and death, are significant in communities across NYS. ASAP recommends that NYS adopt an alcohol harm surcharge that would set aside resources to support problem drinking prevention, treatment, and recovery services. This surcharge could be levied against any business establishment that was found to be in violation of laws or regulations governing the responsible distribution, serving, or other transactions involving alcohol.

Governor Cuomo eliminated the Cost of Living Adjustment (COLA) for chemical dependence and problem gambling and other human services workers in his budget proposal. With a workforce crisis impacting chemical dependence and problem gambling treatment, prevention, and recovery programs, elimination of the COLA will make it even harder for programs to attract and retain staff. We are also concerned about crippling increases in health benefit costs. Our employees are paying more and more out of their own pockets for a shrinking menu of healthcare benefits as rates go through the roof. ***We urge the Senate and Assembly to work with the human service community to explore economies of scale and increased public/private collaboration in the purchase of health insurance and other personnel benefits.*** We also ask the legislature to eliminate the MTA tax to provide relief to human service providers.

We ask the legislature to be vigilant regarding continued work on problems with the social work licensing statute. As you know, ASAP is concerned that the statute has a significant number of unintended consequences that threaten the very existence of chemical dependence treatment and early intervention services. Scope of practice language, if implemented, would result in thousands of layoffs of treatment staff who are currently providing intake and screening services, developing treatment plans, and providing an array of treatment counseling services. Because of the severe budget crisis impacting NYS, it is unlikely we could afford to "upgrade" program staffing to comply with the scope of practice provisions of this statute, resulting in significant service reductions and program closures all across the state.

A serious threat to treatment programs continues to impact our field because of actions taken by the Office of the Medicaid Inspector General (OMIG). Audits in OASAS community-based treatment programs, continue to produce huge disallowances for no reason other than simple clerical or administrative errors having nothing to do with fraud, waste, or abuse. "Take backs" resulting from disallowances not related to fraud have totaled in the tens of millions, threatening the fiscal viability of affected programs. ***We urge the Senate and Assembly to pass legislation that limits OMIG's ability to penalize programs for simple human error not even remotely related to fraud, waste, or abuse***.

ASAP is committed to being a resource for the Senate and Assembly and a partner in your work to improve the quality of life in communities throughout NYS. On behalf of ASAP's membership, I thank you for your service to the public and assure you of our readiness to assist you. With gratitude, ASAP would also like to recognize the dedication and hard work done by Senate Finance, Assembly Ways and Means, Program and Counsel staff, and the DOB team.

Thank you.

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NYSRA New York State Rehabilitation Association, Inc.

TESTIMONY BEFORE THE JOINT FISCAL COMMITTEES

OF THE NEW YORK STATE LEGISLATURE

REGARDING THE 2011-2012 EXECUTIVE BUDGET

MENTAL HYGIENE FUNDING

March 2, 2011

Submitted by:

NEW YORK STATE REHABILITATION ASSOCIATION

Presented by:

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INTRODUCTION

Good afternoon. We very much appreciate the opportunity to offer you our views on portions of the Executive Budget related to mental hygiene issues.

I am Jeff Wise, president and chief executive officer of the New York State Rehabilitation Association.

NYSRA is now in its 32nd year as a statewide trade association of not-for-profit providers of services to New Yorkers of differing abilities. Our providers and their direct-care staff are key components of the state's delivery system of services to people with developmental disabilities, mental health diagnoses, learning disabilities, and other conditions. Our approximately 100 provider agencies deliver myriad services to New Yorkers, including vocational rehabilitation, residential care, and many other person-centered services.

GENERAL THEMES

NYSRA recognizes the difficulties being encountered by New York –and all States – in dealing with the national recession and other fiscal conditions that are straining state resources. While spending cuts are probably inevitable, those cuts must be done in such as way as to ensure that critically important services to people who need them are not eroded or eliminated.

The series of state budget cuts dating back more than two years, including 6 percent mid-year reductions in 2008, the Deficit Reduction of December 2009, and the FMAP contingency cut in September 2010 has had a cumulative impact. We strongly urge the Legislature to weight this budget proposal with that context kept in mind.

We believe that all things funded by state government are "desirable. " Yet, beyond that, some things are certainly "important." And, beyond even those are services and programs that must be considered "essential."

Serving people with disabilities is an essential responsibility that New York has long assigned a very high priority. However difficult the fiscal climate, however urgent the need to cut spending, this high priority cannot be abandoned.

The Governor's Budget Proposal lists an actual global Medicaid cut, from last year's funding levels, of $982 million. This is a considerable reduction and one that, again, we ask be considered in the context of the previous cuts that have been absorbed by our programs and services.

DEVELOPMENTAL DISABILITIES

The Executive Budget includes important support for New Yorkers whose services are delivered through the Office of Mental Retardation and Developmental Disabilities. It also, however, includes broad cuts that we believe will have adverse impacts on the populations we serve.

The Executive Budget Proposal includes a reduction of $73 million in the coming SFY, annualizing the following year to $98 million, in the areas described thusly by the budget documents:

- *Reform the financing of various OPWDD programs through rate, price and contract adjustments to both residential and nonresidential services to reflect efficiencies, program restructurings and other cost savings. These reforms include more aggressive reviews of providers' overall surplus/loss analysis, as well as further constraints on administrative and non personal service costs. Funding for workshop, day training and other day services will be reduced to encourage placements into other more effective community based integrated day and employment programs. In addition, funding for transportation services and residential habilitation services delivered in supervised Individualized Residential Alternative programs will be reduced to encourage efficiencies.*

We remind policymakers that these programs are very much at the heart of services for people with developmental disabilities. We also remind policymakers that this reduction will be matched by a loss of federal dollars that will bring the annual decrease in funding next year to well more than $200 million annually.

If this reduction is not restored and must stand, we must notify policymakers that services in this area will be severely strained and that agencies in their communities may be threatened with insurmountable fiscal challenges.

In the alternative, NYSRA strongly recommends shifting of people receiving services in state-operated facilities to agencies in the voluntary, not-for-profit sector. Considerable savings can be realized by shifting people to the community settings, which are run at considerably lower costs than state facilities. This shift also works to move New Yorkers toward more integrated settings wherever possible.

NYSRA supports regulatory reform as another way of finding savings that would not threaten services and supports for people in the OPWDD system. We stand ready to work with policymakers, identifying regulations that add administrative burdens and costs to the system, doing nothing to truly impact service availability or quality. We think the Governor's Mandate Relief Redesign Team, whose report has just become available, demonstrates that there are many areas that can be investigated for relief. Our first-blush look at the report is that it includes some promising areas of reform that we would strongly support. However, we ask the Legislature and the Governor to go further and to perhaps convene a stakeholder group that would also look closely at the regulatory environment in which all sorts of state-licensed providers are being

asked to operate. The momentum we see created by the Mandate Relief Team's report should be carried through to touch on all areas, not just focus on school districts and local governments.

MENTAL HEALTH

Cuts in the Office of Mental Health, similar to those at OPWDD, will cause certain strains to the system. And we encourage the Legislature to be aware that cuts to mental health services in times of fiscal crisis may be counterproductive down the line.

The Executive Budget in this area does pick up on a theme already mentioned – the shifting of people from state-operated facilities to community provider settings. We support this proposal, which is part of OMH's plan to absorb its 10 percent state operations cut, and we urge that it be considered in the developmental disabilities sector as well.

NYSRA has added our support to the many organizations and others who favor a managed care "carve-out" that would set up regional "Behavioral Health Organizations" (BHOs) that would coordinate care for people with serious mental illness. While we find much that is promising in this item as forwarded last week by the Medicaid Redesign Team, we must ensure that integrated health principles favored by the federal Affordable Care Act (ACA) are not compromised by moving to a BHO model. At this point we believe the model being proposed through the MRT will comport with the concept of "medical home" that the ACA incentivizes and, of course, any impact such a model would have on the availability of overall health care to those who enter a "medical home" through a mental health services doorway.

OFFICE OF MEDICAID INSPECTOR GENERAL

The Executive Budget once again relies on revenue generated by the state Office of Medicaid Inspector General through its audits of community and other providers. NYSRA absolutely supports any and all efforts to truly uncover genuine waste, fraud and abuse within the Medicaid system. We are troubled, however, that the OMIG has become a revenue source for the state that is given targets it must reach. These targets can seem quite arbitrary and may have no relation at all to actual fraud in the field. Moreover, draconian "extrapolation" practices, whereby even honest clerical errors can be magnified into large state demands for recovery of "overpayments," can – and have – placed unnecessary burdens on honest providers, with no evidence of fraud, regarding billings for services that were, in fact, provided to people who need them.

NYSRA supports legislation that is now in each house – A.5686 by Assemblyman Gottfried and S.3184, a "same-as" bill recently introduced by Senator Little. We urge the Legislature to closely consider this legislation, which would do much to rationalize the process by which the state, rightfully, goes after fraud and true waste, while at the same time ensuring that providers are afforded appropriate due process rights and are somewhat protected from potentially devastating rulings that can threaten their very ability to remain in existence.

CONTINUATION OF TAX SURCHARGE

We also join with the myriad other organizations asking you to consider, at least temporarily, generating additional revenue by extending the personal income tax surcharge on New York's highest-income individuals. Extending that tax through the fiscal year would assist in mitigating some of the difficult cuts we are all facing by producing perhaps $1 billion. While we understand the Governor's reluctance to look to tax increases to resolve the deficit, we believe that extension of a tax, already in place, does not impose unfair burdens, but is true to the belief that sacrifice in austere times should be wide shared.

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Families Together
in New York State

Testimony
on the Office of Mental Health Budget

Wednesday March 2, 2011

Submitted to the
Joint Fiscal Committees of the New York State Legislature

The Honorable John DeFrancisco
Chairperson, Senate Finance Committee

and

The Honorable Herman D. Farrell, Jr.
Chairperson, Assembly Ways and Means Committee

Submitted by:
Paige Pierce
Executive Director
Families Together in New York State

My name is Paige Pierce. I am the Executive Director of Families Together in New York State, a statewide family-run organization that represents families of children with social, emotional, behavioral and mental health needs. We represent thousands of families across New York State whose children have been, and are involved in many systems including mental health, substance abuse, special education, child welfare and juvenile justice. Our families include foster families, adoptive families and families headed by relatives.

Our board and staff are made up primarily of family members and youth who have been involved with the various children's systems. I am also a parent. My nineteen year old son was diagnosed with Asperger's Syndrome at the age of three, and ever since we have been navigating the complex systems to find him the help he needs. Painstaking frustrations along the way have, at times, felt unbearable.

There are over one-half million children and youth in New York State who have a mental, behavioral or addiction disorder associated with significant functional impairment.

Without access to appropriate services these children end up dropping out of school: only 30% of children with social, emotional or behavioral disabilities graduate with their classmates. They may end up with repeated, expensive hospitalizations, possibly for attempting suicide. Suicide is the third leading cause of death in New York for 15 to 24 year olds. Too many youth will develop serious addiction problems or end up in juvenile detention. Furthermore, in this state, families still relinquish custody of their children, sometimes voluntarily, sometimes unknowingly, and sometimes forced, in order to receive mental health services in residential settings.

The cost to New York for these children to end up in state custody is extreme: over $200,000 for a juvenile justice placement and over $100,000 for a placement in Residential Treatment Facilities. But more importantly, the cost to the child and family can be devastating.

The state needs to support families in raising their children with special needs. Prompt access to appropriate community-based services enables children to stay in their home while they receive treatment. This saves the state money and improves the quality of life for children, youth, their families and local communities.

Here's what families have told me:

> *"They took my child away from me and put her in foster care. They provided the foster parent with a case manager, with respite and with training on parenting a child with behavioral issues. Why didn't they have those kinds of supports and services for my family? That way we could have stayed together."*

> *"They sent my son to residential placement three hours away. There weren't enough Waiver slots in our county for me to keep my son at home."*

What Families Want:

Families throughout the state have maintained that the services that are most important to them are those which work across systems and provide flexibility to meet the needs of the whole family. Family support services, respite, and the Home and Community Based Waiver are the services that have helped families the most and been most successful in helping them keep their child at home and out of residential programs.

The Good News:

Families Together would like to thank the Office of Mental Health (OMH), the Governor, and all the other child-serving systems for their thoughtful implementation of agency budget cuts. We applaud the proposal to exempt kids, Family Support and Peer to Peer programs in the OMH budget from local cuts. These programs, as I have noted before, are the programs that most help families keep their children at home and in the community. Less costly service options and wiser use of available resources, combined with better outcomes, is a formula Families Together has been working toward in partnership with the child-serving state agencies. Furthermore, this is an important recognition of the priority to build a comprehensive, community-based infrastructure that keeps kids at home and provides them with an opportunity to succeed.

We fully support the proposed downsizing of the Juvenile Justice facilities and the plan to reinvest the savings into community-based services. The Office of Children and Family Service's (OCFS) budget proposes the Performance Based Supervision and Treatment Services of Juveniles Program, which provides funding to local governments to

support alternatives to placing lower-risk youth in costly state facilities. Funding is also added for improvements in mental health, education and direct care in state operated detention facilities.

Our concerns:

As you have heard from a number of groups, the proposed cuts to preventive services is unwise, as juvenile justice facilities are being downsized and the state is looking at ways to lessen the dependence on expensive residential placements in favor of cost-effective and more humane community-based alternatives. This is not the time to cut the very services that prevent expensive placements.

Although these cuts are in the Human Services portion of the budget, they will have a direct impact on all community-based services including those funded through the OMH budget. Youth don't live in agency silos. I've seen estimates that 85% of youth in juvenile justice system have a social, emotional or behavioral disability in need of treatment. As youth are sent home or diverted from juvenile justice placements, they will need their mental health services in community settings. We must make sure that communities across the state are able to provide these essential services.

Policy Priorities for New York State:

1. **Reinvest a portion of the funding from the closure or downsizing of all residential facilities in child-serving agencies** (including but not limited to juvenile justice facilities). This would include any downsizing of Residential Treatment Facilities, Residential Treatment Centers and Children's Psychiatric Centers, into cross-systems community programs for children and youth at risk.

2. **Support the proposal to protect the small peer-run family support programs from any and all local budget cuts.** OMH has exempted Peer to Peer and Family Support from local budget cuts. These programs are often those that families turn to when they have nowhere else to go - and we are likely to see an increased need for these services as other programs are cut. We are grateful that OMH has recognized the importance of these programs, however many of these small programs receive funding from a variety of sources (including preventive services) and they are likely to receive budget cuts

from these other funding streams as the need for their services will increase. One family support worker told me:

> *"I don't know what to do. We lost a grant from United Way and will have to lay off our part-time family support worker. That leaves only me in this county. I have over 70 families that I am currently trying to help and I have never turned anyone away. I do what I can, but I don't know how I'll be able to keep it up."*

3. **Promote the development of a cross-systems community entity** in each locality such as the Children's Coordinated Services Initiative (CCSI) to develop individualized, cross-systems plans for youth at risk of residential placement or youth returning home from residential placement. This entity should be involved in determining how reinvested funds will be used and should include families and youth in the decision making process.
   At the statewide level, the work of the Commissioner's Cross-systems workgroup under the Council of Children and Families should be continued. This entity should be involved in overseeing the planning, implementation, study and evaluation of children's services across state agencies and providing support to local programs.

4. **Restore cuts to the Parent's with Psychiatric Disabilities project.** Although this is a small program, it has helped countless families get the support they need to keep their children at home.

5. **Restore the proposed cuts to community-based services in the OCFS budget totaling over $90 million including Home Visiting, COPs, and preventive services. Restore funding to TANF programs including Alternatives to Incarceration and Summer Youth Employment.**

We must use this difficult financial time to transform the system of care for children with social, emotional and behavioral disabilities and their families into a truly cross-systems, youth and family centered, community-based system. The mandate to do business differently is clear and unmistakable.

Summary

There is agreement that community-based services are needed to keep children and youth out of expensive placements. It is clear that our communities must have capacity to support children in their communities to prevent expensive residential placements, and realize better results! Developing a full array of community-based services including children's mental health services and family support is not only cost-effective but is more effective in treating children and limiting trauma to the child and family.

The child-serving agency commissioners have clearly designed their budgets to make best use of limited funds. Evident in its budgetary decisions, the Office of Mental Health has demonstrated the importance of children's services - but these services are sure to strain under the pressure of the downsizing of the juvenile justice facilities and the cuts in preventive services. More is needed to ensure adequate community supports for youth and families.

We agree that coordination across agencies is the best way to move forward and make use of limited resources. The Cross-systems Commissioners Committee, made up of nine child-serving agency commissioners, must be maintained and relied upon as a resource in promoting a restructuring of children's services and to coordinate agency resources on the state and local levels.

We look forward to working with the Legislature, the Office of Mental Health, the Office of Children and Family Services, the Council on Children and Families and all child-serving systems to ensure that families and youth are appropriately served in their communities and able to stay in their homes to the greatest possible extent.

If there is a single message I would want to leave with you today, it is that families have a greater vested interest, and expertise to ensure the success of our children than perhaps any other stakeholder in our state. We are a strong, informed voice that can be helpful to you as you make decisions that will affect children's lives in our state. Please view, value, and use us a resource and as strong allies and partners.

Thank you.

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Mentally ill deserve better care

By D.J. Jaffe

Gov. Andrew Cuomo is to be commended for creating the Spending and Government Efficiency Commission to right-size state government. Its first recommendation should be to eliminate the Office of Mental Health -- something that could save money and, counterintuitively, improve care and keep the public safer.

Eliminating the agency may sound extreme, but it's not without precedent. Or success.

In the 1990s, the New York City Department of Mental Health, Mental Retardation and Alcoholism Services suffered from a bad case of mission creep, just as the Office of Mental Health does.

Rather than providing services for the most seriously ill, the city agency cut those and ramped up social service programs for others. The seriously mentally ill went to the back of the line, and the worried-well to the front.

In 1999, New York City residents voted to revise the city charter to eliminate the mental health department and subsume any important operations under the health department. The result has been a more streamlined operation that uses its limited resources for what was most important: helping with the medical needs of the most seriously mentally ill.

The mission creep at the state mental health agency is expensive, extensive and sometimes deadly. According to 2010 state budget testimony, the agency spends more than $3 billion to serve 650,000 people. Only 3,600 are seriously mentally ill individuals in state hospitals, according to agency statistics. Another 1,871 are in assisted outpatient treatment programs.

While other programs also serve the seriously ill, these two programs, serving the long-term medical needs of the most seriously ill, represent less than 1 percent of those the agency serves. A nationwide study by the Treatment Advocacy Center and me estimates that New York needs 4,311 more hospital beds for the seriously ill to meet minimal requirements.

Assisted outpatient treatment, better known as Kendra's Law, is New York's most successful program for the seriously mentally ill who are likely to become violent. It allows courts to commit some historically violent patients to stay in violence-preventing treatment as a condition of living in the community.

A 2005 Office of Mental Health study compared what happened to individuals for six months before they entered the program and for six months in the program. It showed that 83 percent fewer were arrested when in the program, 87 percent fewer were incarcerated and 55 percent fewer engaged in suicide attempts or physical harm to others. Expensive hospitalization was reduced 77 percent.

But by failing to adequately fund Kendra's Law, and opposing reforms proposed by Assembly member Aileen Gunther, D-Sullivan County, the agency has effectively capped enrollment at 1,900 people. Using the best available data, Dr. E. Fuller Torrey estimates that more than 4,000 New Yorkers with schizophrenia who need assisted outpatient treatment are not receiving it.

Because the agency has taken its eye off the prize, a lot of the money spent on the seriously mentally ill is wasted. According to Dr. Lloyd Sederer, agency medical director, New York prematurely discharges mentally ill patients and substance abusers from hospitals and does so without community supports. He estimates the cost in potentially preventable hospital readmissions is $665 million (22 percent of the office's budget.)

Another result of letting the seriously ill go untreated, is that the New York criminal justice system had to create an expensive shadow mental health system. The National Sheriffs Association reports that in New York, you are three times more likely to go to prison for serious mental illness than to be treated in a hospital.

Closing the Office of Mental Health won't be easy, only smart. While Commissioner Michael Hogan testified during budget hearings about the importance of integrating mental and physical health, the agency may fight to maintain the status quo.

And when you spend $3 billion annually, you tend to have a lot of friends. Expect 2,500 community programs funded by the agency to drive busloads of clients to Albany to protest.

Cuomo has the opportunity to save money, start to balance the budget, improve care for the seriously mentally ill and keep the public safer. It requires euthanasia and reincarnation: Eliminate the Office of Mental Health and place programs that serve the seriously mentally ill within the Health Department.

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NEW YORK POST
Updated: Thu., Dec. 16, 2010, 4:18 AM

They didn't have to die

By DJ JAFFE
Last Updated: 4:18 AM, December 16, 2010
Posted: 10:40 PM, December 15, 2010

On Monday, Ryan Devaney stabbed both his parents. The mentally ill Brooklynite killed only one, his mom. In October, mentally ill Staten Islander Eric Bellucci stabbed *his* parents, killing both. In November, Suffolk County police had to shoot and kill mentally ill Thomas Scimone after he threatened to shoot firefighters and ran through West Babylon brandishing a gun.

"When he was on his meds, you would never believe he was bipolar," said a relative.

None of this had to happen. Thomas Scimone, Ryan Devaney and Eric Bellucci were seriously mentally ill and needed ongoing medical help. But all were abandoned by programs "certified" by the Office of Mental Health until they oh-so-predictably became violent.

Gov.-elect Andrew Cuomo can stop these needlessly repetitive and horrific events by hiring a mental-health commissioner who'll prioritize services for the most seriously mentally ill. This would save money, improve care *and* keep the public safer.

The Office of Mental Health is the state's largest agency, with a budget of $3 billion. It spends more per-capita than any other mental-health system in the country -- yet the seriously mentally ill remain seriously underserved.

The problem is unmitigated mission creep. The solution is returning OMH to its roots.

The predecessor organizations to OMH were founded to help those with "lunacy" or who were "mentally defective." While those terms are offensive today, it was a narrowly focused medical mission that did what the public wanted: Help the most seriously ill.

Today, OMH has largely abandoned treating serious mental illness in favor of implementing social programs for the "worried well" -- less symptomatic people with bad grades, unhappy marriages or other loosely defined "behavioral" or "trauma" issues. Community programs that focus on mental health cheer OMH largess, while those that treat mental illness disappear.

Yes, OMH provides services to some seriously mentally ill individuals: 4,000 in state psychiatric hospitals and 1,850 receiving court-ordered mental-illness treatment in the community, plus a few others in day-treatment programs like Fountain House. But OMH continues cutting back.

In 1993, our state had 10,500 psychiatric hospital beds for the most severely ill; today, it's only 4,000 -- and the plan is to go even lower. The Treatment Advocacy Center estimates New York would have to add 4,311 beds to meet minimum requirements. Instead, OMH continues to provide taxpayer-funded services to 640,000 other New Yorkers.

What services? According to OMH, ones that focus on the "developmental, physical, emotional, social, spiritual, educational and concrete daily living needs (e.g., housing) of children" and "provide hope-filled, humanized environments and relationships in which people can grow."

The result of OMH's abandonment of its medical duties for a social-services agenda: According to Dr. E. Fuller Torrey of the Stanley Medical Research Institute, the most seriously mentally ill in New York are now 1.2 times more likely to be arrested than treated.

Rikers Island has become New York's largest psychiatric hospital, Ryan Devaney and Eric Bellucci its newest inmates.

As governor, Cuomo will decide who will lead OMH. Hiring a commissioner with an MD (which the law used to require) who is committed to making serious mental illness -- rather than social-services programs -- the priority would be the right prescription for a sick department.

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March 2, 2011
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Our perspective is different:

- We do not focus on mental health or behavioral health. We focus only on serious and persistent mental illness.
- We take no money from OMH so we can be honest.
-

Two Overall Recommendations:

1. **Eliminate OMH and merge it with Department of Health (perhaps via Cuomo's SAGE Commission) or take other action to force it to focus on its original charter of focusing on serious mental illness.**
2. **Close the loopholes in Kendra's Law**

The problem at OMH is unmititgated mission creep. (Huffington Post (5/24/2010); NY Post (12/16/10) Albany Times Union (1/28/11), and Manhattan Institute. The Commissioner has variously stated the mission is to

- *promote the mental health and well-being of all New Yorkers. (2010 Framework)*
- *Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health*
- *Eliminate stigma, create jobs, etc.*
-

Predecessor organizations to OMH were founded to help those with "lunacy" or who were "mentally defective." Those terms are offensive today, but it was a narrowly focused medical mission that did what the public wanted: Help the most seriously ill.

Under Commissioner Michael Hogan, OMH continues to spend their resources on the 50% of New Yorkers OMH says will have a diagnosable mental health issue during their lifetime — everyone from struggling students to dissatisfied spouses—rather than the 3-9% they acknowledge are the most severely impaired—primarily those with real serious mental illnesses like schizophrenia and bipolar disorder.

A stark sign of the state's failure to failure to focus: there are currently more mentally ill individuals in prison on Riker's Island than in any OMH-run psychiatric hospital.

OMH's main goal seems to be increasing the raw number of people it serves, rather than helping the most seriously ill. In budget testimony last year, OMH Commissioner Michael F. Hogan claimed the agency was serving 650,000 individuals. This year, that number has shot up to 700,000—but only 3,600 are seriously mentally ill individuals in state hospitals, according to the agency's statistics. Another 1,883 seriously ill receive treatment in assisted outpatient programs, and perhaps a few tens of thousands others are scattered throughout the system. Who are the hundreds of thousands of others? Commissioner Hogan describes them as individuals who need "hope filled, humanized environments and relationships in which people can grow." Many are individuals who circulate needlessly through psychiatric emergency rooms due to their inability to get care. Dr. Lloyd Sederer recently estimated needless hospitalizations of mentally ill is wasting $665 million a year in New York. He attributes a lot of this to the failure to combine health and mental health.

OMH is focusing cuts on people they should be focusing on: people with serious mental illness.

Governor Cuomo's 2011 budget makes a net 2.6 percent cut ($95 million) in OMH's $3.6 billion budget, a reduction that would mean little if the agency spent the remainder on the right things. The cut consists of $135 million in spending reductions offset by a $40 million increase to comply with a specific court order, which requires OMH to stop abusing people with serious mental illness in non-therapeutic group-adult homes meant to house the elderly indigent, and move them into supported housing that provides case management, medication, and rehabilitation services. You may remember that OMH also had to be sued to give seriously mentally ill the right to atypical antipsychotics, fresh air in hospitals, and housing in NYS as part of NY/NY agreement. The only way OMH focuses on the seriously ill is when they are forced to by law suits or legislation.

One might expect that this requirement would result in new housing units for people with serious mental illness, but a close look at the budget shows otherwise. OMH intends to fund the "new" housing for this population by taking housing away from *other* seriously mentally ill individuals. OMH is eliminating funding to families willing to take in and house the seriously ill, freezing community residential programs, and "reprogramming" 250 scatter-site beds for people with mental illness who can live safely in the community. In other words, the agency is robbing Peter to pay Paul. The $40 million that looks like an increase in housing for the seriously ill is largely a wash, offset by the discontinuation of other housing programs.

The proposed budget anticipates that the lion's share of the $135 million in cuts will come from a combination of cutting back on services for the most seriously ill and reducing the workforce that provides those services. As Cuomo's budget blandly put it, in 2011 "OMH will reduce State-operated inpatient capacity based on a review of current census patterns." But using census data, a nationwide study I co-authored with lead author E. Fuller Torrey and the Treatment Advocacy Center estimated that New York needs 4,311 *more* inpatient beds to meet the minimal needs of the seriously ill, not less.

The proposed budget also contemplates reducing staff in the state psychiatric hospitals, which still accept the most seriously mentally ill as patients. These cuts could be particularly problematic, given that a number of those hospital beds are now occupied by Sexually Violent Predators. New York has already dramatically reduced state psychiatric hospital beds, from 10,500 in 1993 to 3,600 today. Cuomo's budget forces more hospital closings, a process that will likely result in an increase in homelessness and incarcerations. Under the rubric of "restructuring," moreover, OMH will "rationalize" (in other words, cut) "the reimbursement of providers of mental health clinical services," who provide prescriptions, case-management, counseling and medical services to people with serious mental illness in the community. In short, the 2011 budget continues the expensive and inhumane policy of focusing cuts on people they should be focusing on: people with serious mental illness. We all remember when Marcy was a state psychiatric hospital. Today it's a jail with many of the same people who were kicked out when the hospital was closed.

Solution: Legislatively force OMH to focus on the sickest, rather than the greatest number

1. Ask Cuomo to replace Current Commissioner with an M.D administrator.
If the legislature wants to save money, improve care, and keep the public and patients safer, force major reform at OMH. A new commissioner—perhaps one with an M.D., as was formerly required—might be more willing to return focus to treating mental "illness" as opposed to improving mental 'health".

2.**Work with Governor Cuomo's Savings and Government Efficiency (SAGE) Commission and propose eliminating the Office of Mental Health. Its vital functions—those that actually have to do with serving the seriously mentally ill—should be transferred to the medical auspices of the Department of Health.**

Almost every organization that is appearing here today, including Commissioner Hogan, Dr. Sederer, NYAPRS, MHA, and NAMI have called for better integration of health and mental health. I agree and this can be accomplished by merging the departments.

In the 1990s, the New York City Department of Mental Health, Mental Retardation and Alcoholism Services was as overextended as OMH is today. Like OMH, the city agency cut services for the most seriously ill and expanded social-services programs for others. **In 1999, residents voted to eliminate the agency and combine its vital operations into the health department. Limited resources were then directed to where they were most needed.**

3. **The committee should establish a definition of serious mental illness that covers no more than 5 percent of the population and require all programs that get OMH money to use at least 60 percent of the funds for this defined population**. State and local hospitals and hospital workforces that provide care to seriously mentally ill patients should have their resources increased, not cut.

4. **Put OMH's operations under sharper scrutiny.** Rather than merely reporting increases and decreases in categories of spending, it should provide details about where every dollar is spent. OMH sends funds to 2,500 nonprofits serving 700,000 individuals. Some do excellent work, but many don't serve people with serious and persistent mental illness. The amounts and purposes of those expenditures should be put on the Internet so that taxpayers can evaluate them. The *New York Post*'s Andrea Peyser revealed that OMH is funding an organization that purportedly managed money for people with mental illness, but instead was giving the funds directly to patients, knowing they'd often use it to purchase illicit drugs.

5. OMH's research budget should also be rigorously scrutinized—and, if OMH refuses to restore a focus on serious mental illness, probably eliminated. It pains me to say this, because OMH conducts research at New York State Psychiatric Institute and Nathan S. Kline Institute that can save money, improve care, and keep the public and patients safer if patients had access to it. Specific examples include the benefits of atypical antipsychotics (for schizophrenia); ECT (for depression); AOT (for people with mental illness and anosognosia; and ethno-pharmacology (to improve treatment within multi-cultural populations). But because OMH won't implement the research, few benefit from it. **The research enhances the prestige of OMH but not outcomes for patients.**

6. Close the loopholes in Kendra's Law (See att).

Close the loopholes in Kendra's Law

Since its original passage in 1999 over the objections of OMH, and with support of mental illness and public safety advocates, Kendra's Law has been the subject of several studies which found Kendra's Law helps people with serious mental illness by:

- reducing homelessness (74%);
- reducing suicide attempts (55%);
- reducing substance abuse (48%);
- reducing physical harm to others (47%)
- reducing property destruction (43%).
- Saves money by reducing hospitalization (77%);
- reducing arrests (83%);
- reducing incarceration (87%).

In addition, these studies and others found none of the fears expressed by NYAPRS, were true. The law doesn't increase stigma, it lowers it; it doesn't 'target' minorities, it gives them equal access services NYAPRS described as "the best". It doesn't scare people from seeking services it increases compliance; it didn't take away services from others, it led to fewer demands on the system. **And most importantly, consumers actually in the program say they think it helped them.**

The legislature should close the following loopholes in Kendra's Law which would save money, improve care, and keep both public and patients safer.

1. Close the crack in the system, whereby prisoners who relied on mental health services while imprisoned are discharged without determining if they need mandatory treatment to stay healthy and prevent them from becoming violent.
2. Close the crack in the system, whereby individuals who are involuntarily committed to inpatient treatment because they are 'danger to self or others' can be released without first determining whether they need mandatory treatment to help them stay healthy and prevent them from becoming violent
3. Close the loophole whereby if a person under court order moves to a different county, the order to stay in treatment is no longer enforceable
4. Close the crack in the system whereby court orders can expire without a review of whether they should be renewed.
5. Clarify that a county should investigate reports of individuals in need of AOT received from family and community members in addition to hospital directors.
6. Require physicians to make a reasonable effort to gather useful information from the consumer's family or significant others.
7. Allow commitments to AOT to be for up to one year in order to Incorporate findings of research requested by legislature that shows treatment orders of one-year have a more sustained positive impact than shorter length orders.
8. Allow doctors to presume under certain conditions that patients who *materially violate* their treatment orders should be taken to a hospital to see if they need admission.

If New York State wishes to save money and improve care for the seriously mentally ill—and yes, lessen the chances of an Arizona-like incident here—you must address the failure of the Office of Mental Health to assist the population it was designed to serve.

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New York State Senate and Assembly
Joint Session on
FY 2011-2012 Executive Budget for Mental Hygiene
March 3, 2011

Supportive Housing Network of New York
Ted Houghton, Executive Director

Good afternoon. My name is Ted Houghton, and I am the Executive Director of the Supportive Housing Network of New York. The Network represents over 200 nonprofit providers and developers who operate over 43,000 supportive housing units throughout New York State, the largest supportive housing membership organization in the country.

Supportive housing – permanent, affordable housing linked to on-site services – is the proven, cost effective and humane way to provide stable homes to individuals and families who have difficulty finding and maintaining housing. The people we house and serve – people with mental illness, HIV/AIDS, substance abuse, and other barriers to independence – are typically frequent users of expensive emergency services like shelters, hospitals, prisons and psychiatric centers. Because placement into supportive housing has been proven to reduce use of these services, supportive housing saves State taxpayers' money, often far more than what was spent building, operating and providing services in the housing. This has been proven, time and time again, by dozens of peer-reviewed academic studies.

Thank you for the opportunity to testify today. I would like to take the time to talk about the proposed cuts to community mental health services, the proposals of the Medicaid Redesign Team, expanding permanent housing for people with psychiatric disabilities and ensuring that there is sufficient funding for housing people with a history of substance abuse.

Alternatives to Proposed Cuts to Community Mental Health Services
This year's Executive Budget proposes a 3.6%, $121 million cut to the overall budget of the New York State Office of Mental Health. About $27 million of

this is to mental health services in the community, as well as some State aid to localities. This is on top of the continuation of the freeze on Cost of Living Adjustments (COLAs) to staff in community-based mental health programs. Finally, last year's 1.1% cut to funding (with no accompanying reduction in the amount of services delivered) will be made permanent.

A better way to find equivalent savings would be to support the proposal of the Association for Community Living (ACL) to contract out to nonprofits community residences that are currently directly-operated by the State. This could save tens of millions of dollars. If this was accompanied by further reductions in State Psychiatric Center inpatient spending, we likely could avoid cuts to community mental health altogether.

Medicaid Redesign Team

The Governor's Medicaid Redesign Team (MRT) voted last week to support an extraordinary package of proposals that will have enormous consequences for our mental health system. The proposals were broadly worded and considered very quickly, so it is difficult to know their full effect at this time. Certainly, the devil is in the details.

Briefly, here are some of our concerns:

Behavioral Health Services Carve-Out: We strongly support the continued carve-out of behavioral health services from mainstream managed care. Proposal 93 will establish interim behavioral health organizations to manage behavioral health services as we move toward a more integrated model of service delivery. Using specialty Behavioral Health Organizations (BHOs) to at first coordinate care, and over two or three years move toward what is likely to be a managed care model is vastly preferable to just turning over the behavioral health population to mainstream health plans that have had little experience with the high-need behavioral health population.

In some other states, BHOs have had success reducing costs, improving care and establishing innovative new approaches to mental health when states have taken a strong interest in managing them. We are pleased that the MRT proposal charges the State Office of Mental Health with managing this process. We believe that present OMH leadership will be in the best situation to manage the transition to managed care, to ensure that contracts with BHOs not only

restrict profits and administrative costs, but also follow recovery model of care with a central role for peer initiatives.

And in reducing costs, some BHOs have been able to reinvest savings into the creation of new supportive housing opportunities. Stable, appropriate and affordable housing is essential to mental health recovery. Expanding access to housing should be a central goal of this effort.

As we move forward, it will be important to have both mental health advocates and providers fully involved in the process. At the present time, we strongly urge you to support Proposal 93 as written.

Prescriber Prevails: We do not support a provision in the MRT proposal that would restrict access to specific medications for people with special needs, including those with psychiatric disabilities and HIV/AIDS. Medications for these groups are excluded from the State's Preferred Drug Program because the State has always recognized that there can be long-term harm done to people with serious conditions when they are denied access to the drug that works best for them and are made to "fail first" on another state-approved drug. We expect that improved care coordination by BHOs will achieve significant reductions in costs this year, making reducing access to certain medications unnecessary. Rather than imposing prior authorization on vulnerable populations who have often had difficulties finding the medication most effective for them, this MRT proposal should be eliminated so that the "prescriber prevails" as to deciding the best course of medication for their patient.

Utilization Controls on Behavioral Health Clinics: The MRT proposes to further limitations on the number of visits one individual can make to clinics. We do not support further reducing payments to clinics as they try to provide an adequate level of services to the most challenging to serve.

Maximizing Peer Services: The Network's providers have found that expanding peer support and employment opportunities have been central to the success of our housing and programs. Peers are uniquely qualified to help other residents achieve recovery, so we are pleased to see the MRT put particular emphasis on using Medicaid to fund peer supports utilized in new health homes.

Triple New York City's Managed Addiction Treatment Program (MATS): The MATS case management program in New York City has shown promising success in lowering Medicaid costs and improving coordination of care for people with substance abuse issues. We are pleased to see it expanded.

Supportive Housing Interagency Workgroup: Lastly, we are pleased to see the MRT propose a workgroup to develop a proposal by July 1st to create between 5,000 and 10,000 housing opportunities for persons at risk of nursing home placements. We strongly support this effort and urge that the workgroup include representatives of nonprofits who are expert in supportive housing development and management. It is important to have at the table the people who actually operate this housing, who have developed and perfected the effective service models that have made supportive housing so successful. We further urge that the proposal explicitly give OMH a leadership role in this effort. While the Department of Health has made a little progress in the past four years to improve its record on housing, and has begun to support new housing initiatives, OMH now has thirty years of experience in this field. The housing created by the partnership of OMH and the State's housing agencies has in particular provided the most integrated and best quality housing for vulnerable populations. It is important that the any housing created as an alternative to nursing homes is not just a less expensive nursing home, but is instead is as close as possible to a permanent apartment well-integrated into the community with all the comforts of home, linked to any essential services that ensure the tenant's independence.

Expand Mental Health Housing

While we are excited at the prospect of the MRT's new supportive housing initiative, we are concerned that the State Office of Mental Health has been forced to back away from its current commitments to expand permanent housing for people with psychiatric disabilities. We know that supportive housing achieves substantial savings when targeted to populations who use a lot of emergency services. The sooner we create this housing, the sooner we can achieve these savings at the same time we improve the quality of their lives.

New York has led the nation in creating supportive housing models that increase people's stability and independence. Our State Office of Mental Health was probably the first in the country to recognize the importance of stable, affordable housing in mental health recovery, and has made an enormous commitment to expanding housing opportunities for this

population. We appreciate the leadership that OMH has demonstrated in maintaining their commitment to the New York/New York III Supportive Housing Agreement, the 10-year City/State commitment to create 9,000 new units of supportive housing in New York City. Certainly, OMH deserves high praise for helping to measure and demonstrate the public savings associated with supportive housing, leading many other states and localities to launch major investments in expanding supportive housing for vulnerable populations in order to lower their own spending on expensive emergency interventions.

Next door in Connecticut, the Governor there has proposed a major new supportive housing development initiative because he knows supportive housing is one of the quickest ways for his state to achieve savings. Here in New York, Governor Cuomo likewise protected capital funding for affordable housing at the State housing agency. But we were dismayed to see that the Executive Budget proposes to "freeze" spending on supportive housing production.

Unfreeze Growth of Supportive Housing: There are many reasons to support an expansion of affordable housing development: the housing shortage downstate is the worst it has ever been; affordable housing has proven to improve all sorts of social, educational and health outcomes; and housing construction is an effective driver of economic growth.

Supportive housing development also achieves all of these goals, but in addition, it greatly reduces the use of shelters, hospital emergency rooms, psychiatric centers and a whole range of expensive emergency interventions. When a multiply-disabled homeless individual is placed into a supportive housing unit, public costs go down immediately, usually far in excess of the cost of the initial public investment.

This year's Executive Budget proposes to freeze all new capital and expense budget spending on Community Residential Programs for a year. For the development of new apartment buildings, this freeze will save little or no money this year, as almost all of the capital funds will actually be spent the following year or two, when capital construction commences. The freeze will only serve to stop OMH from approving new residences from moving forward.

Freezing scattered-site units saves money this year, but only on paper. At present, over 1,600 units statewide are already "frozen." This proposal puts hundreds more in limbo. Many of these units are scattered-site rentals linked to service funding that could be rented up and filled with currently homeless, ill-housed and institutionalized people in a matter of months. By freezing them, we are condemning these vulnerable individuals to unhealthy, restricted lives, while continuing to force ourselves to pay for the high costs associated with sheltering them in inadequate or inappropriate settings.

The sooner we build and create more supportive housing, the sooner we begin to save. At the same time, we improve the lives of vulnerable people, as well as the quality of the communities in which we live. The economic activity generated helps fuel our State's economy now, even as most of the costs will be borne in the future when the State is in better fiscal shape. The Medicaid Redesign Team has come to understand this and has proposed a major new housing initiative; there is no reason to ignore this concept here and go in the opposite direction. We urge you to convince the Governor to strike out language that freezes the creation of new units and accelerate production of new supportive housing units for people with psychiatric disabilities.

Adult Homes: One reason given for the freeze on supportive housing expansion is that OMH must respond to a 2010 Federal court order to provide housing and services for 4,500 individuals living in some large, proprietary adult homes in New York City. This year's executive budget proposes to take 250 units of this development pipeline and "reprogram" these beds to meet adult home litigation requirements. Much of the funding required to pay for the new units for adult home residents comes at the expense of homeless shelter residents with psychiatric disabilities who will have to wait longer for housing to be created for them. In effect, the litigation does little more than put one vulnerable population with psychiatric disabilities, adult home residents, ahead of the line of another – homeless people.

After more than a decade since the New York Times exposed the dreadful conditions in adult homes, the money has at last been budgeted to pay for the housing that will finally allow adult home residents to move to integrated housing in the community. However, just last week, a decision was made by the court to grant the State a stay that allows it not to meet the requirements of the court order to house adult home residents until the litigation is completed.

Just because the court case continues, there is no need to delay justice for the adult home residents. The State should continue with its initiative and activate the contracts awarded by the recent RFP and begin filling the units while the litigation winds its way to resolution. The stay actually provides us an opportunity to address the need to provide housing and services to the people currently living in adult homes in New York City, as well as homeless people, through a more collaborative, cost-effective and meaningful way. Budgeted scattered-site supported housing units can be offered to adult home residents, but also to residents of existing supportive housing residences who are ready for more independent living. Adult home residents can then be offered a broader choice of moving into the vacancies created in these residences, giving them more options in where and how they want to live. Both populations get housed, more quickly, and both get more choices. And it's already in the budget. Everybody wins.

Specifically, the Network is requesting the Legislature to:

- Move forward with spending the $40.3 million originally budgeted for the adult home litigation to rent up supported housing in the New York City region;
- Allow the 1,600 OMH supportive housing units now frozen in the statewide development pipeline to move forward; and
- Do not freeze new OMH Community Residential programs for one year and allow the continued investment in supportive housing to proceed.

Meeting the State's Commitment to House People with a History of Homelessness and Substance Abuse

The NYS Office of Alcoholism and Substance Abuse Services (OASAS) is also a state partner in the New York/New York III Agreement. Of the 9,000 units in the Agreement, OASAS is committed to funding the rental subsidy and service funding for 750 of them. To fully fund the New York/New York III units that are open or opening this year, OASAS needs $11.6 million in the SFY 2011-2012 budget.

In the first five years of the initiative OASAS has met their commitment in full. Unfortunately the Executive Budget did not include language specific to OASAS' New York/New York III housing and we have been unable to get confirmation from the Administration regarding this budget line.

There are 1,057 formerly homeless and at-risk individuals with a history of substance abuse that are stably housed because of this funding. We must do everything in our power to ensure that they do not end up on the street again. Therefore we urge the legislature to confirm that this funding is indeed in the budget for 2011-2012 and work to restore this funding if it is not.

Conclusion

This year's Executive Budget proposes extensive cuts in just about every area of services and supports that help poor and middle class families and individuals who struggle to maintain a decent quality of life in New York State. Even if we are able to restore the most destructive of these cuts, the consequences of a smaller budget are going to a have a damaging effect on millions of vulnerable New Yorkers.

At the same time, more, ill-advised cuts are being proposed in Washington that are likely to send our economy back into recession. This will further increase the need for low-income housing subsidies, homelessness prevention, community-based services and employment programs, just as these very same programs are being sharply scaled back. It is going to be a very difficult year.

Extend the Personal Income Tax Surcharge

That is why we must take a moment and appeal to you to extend and make permanent the Personal Income Tax Surcharge. I am all for slowing the growth of the State budget, and finding new efficiencies and savings. Some proposals to curb spending are quite promising. But if this budget is truly going to be fair, if it is going to spread the pain evenly, we must ask the very wealthiest New Yorkers to contribute during this time of need. A huge portion of our $10 billion budget deficit is caused by allowing the PIT Surcharge to expire. The least we can do is to ask New Yorkers who continue to earn large incomes to pay a fair tax rate.

There are a number of compelling reasons to support the surcharge:

- People earning over $200,000 a year have, on average, seen their incomes double over the past seven years. The rest of us have seen our incomes barely keep up with inflation.

- At the same time, wealthy taxpayers have been very successful at getting steady decreases in the amount they are taxed. Over the past 25 years, the marginal tax in the top brackets has been reduced from more than 15% to less than 7%.
- The very wealthiest New Yorkers earn most of their income through profits off of investments, for which they pay a capital gains tax of just 15%. The rest of us who earn our pay by working for it must pay rates that approach twice that. With so many low income and middle class families struggling this year, how can we justify this inequity?
- Most of the $5 billion secured by extending the surcharge would otherwise be accumulating in rich people's accounts all over the globe, generating very little economic activity in New York. If it is instead collected by government and spent locally to provide critical safety net supports and preserve teaching, public safety, social service and other essential jobs, it will create the economic multiplier effect we need to pull our state out of recession.
- State income taxes are deducted from federal income taxes, meaning that one-third of the surcharge will be paid for by the federal government, doing a little to correct the structural imbalance that has New York paying far more than it receives from the federal government.
- This is NOT a tax increase. It is a continuation of a current tax.

We urge you to respond to the wishes of 78% of New Yorkers and extend the personal income tax surcharge. To go against the interests of the vast majority of the public in order to aid the very wealthy would just confirm to them that money is all that matters in our legislative process. Remember, this budget proposes to make over ten thousand formerly homeless families and individuals who are now housed homeless again; it will eliminate daycare for women who have got off welfare and are now working, meaning they will go back on public assistance. It will cause localities to close senior centers, lay off teachers, and reduce funding for food pantries that are already overwhelmed by the demand. To give a tax break to the fortunate few, while hundreds of thousands of poor children across New York State are literally going without dinner, is unconscionable. I hope that you will fight for the extension of the surcharge so that we can restore the essential supports and services that help our most vulnerable citizens and make New York State a great place to live.

Thank you for this opportunity to testify.

Respectfully submitted by:

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Cerebral Palsy Associations of New York State

Testimony

Before the

NYS Senate Finance and NYS Assembly Ways & Means Committees

Presented by

Barbara Crosier

Vice President, Government Relations

March 2, 2011

90 State Street, Suite 929, Albany, NY 12207 * (518) 436-0178 * Fax: (518) 436-8619

Good afternoon Chairman Farrell, Chairman DeFrancisco, members of the Senate Finance Committee, Assembly Ways and Means Committee and the Mental Health and Developmental Disabilities Committees. Thank you for your ongoing support for people with disabilities and for the opportunity to speak with you today regarding Governor Cuomo's 2011 budget. I am Barbara Crosier, Vice President, Government Relations for the Cerebral Palsy Associations of NYS – founded over sixty years ago by parents seeking services for their children with disabilities. Since that time, 24 CP of NYS Affiliates throughout the state have been offering a wide array of services for children and adults with disabilities and their families. While originally focused on children with cerebral palsy and other physical disabilities, our services have expanded to include children and adults with all types of disabilities and a variety of supports and services throughout their life span. Today CP Affiliates offer a variety of programs and services to over 90,000 people and their families across the state, and we employ over 18,000 New Yorkers.

In addition to the OPWDD programs, which include operating IRAs, ICFs, CRPs, Residential and Day Habilitation, Family Support and Respite Programs, and Community Residences, our Affiliates operate Early Intervention, Preschool, School-Age Programs, Article 16, 31 and 28 Clinics, and FQHCs. Our programs are approved under: OPWDD, SED, DOH, OMH and OASAS.

- Of the Affiliates' 2009 total expenditures of $891 million, OPWDD funding accounts for 70.2% of that total.

- CP programs rely heavily on personnel, with almost 73% of our total expenditures being salary and fringe benefit costs.

- The CP Affiliates as an entity have been running our programs very close to the edge, with our agencies netting a loss across all programs. That deficit is only

made up by fundraising and other community supports, the total for which has dropped as times have gotten worse.

- Finally, the CP Affiliates run efficient organizations, which is demonstrated by, among other indicators, our very lean 8.3% average agency administration costs.

I offer these facts to say that despite lean operations, as community organizations, we accept responsibility in meeting unprecedented financial crises and we are willing to take our share of the cuts. However, we ask that the disability provider community not be disproportionately harmed by the various components in play in this year's somewhat cryptic and complicated budget process.

On one hand, the Governor has stated that we are being asked to take a 2.7% cut. However, our estimates, using DOB statistics, show the real impact on disability service providers may be closer to a 6% or 8% cut and $230 million. Part of our concern and frustration is that in past years we worked in partnership with OPWDD to take the cuts in a way that least impacted people with developmental disabilities. This year we do not know what the dollar or percentage is that must be cut and we are very fearful that the amount will continue to grow, leaving people with severe disabilities in jeopardy.

In addition to these potentially devastating cuts in OPWDD, there appear to be a number of proposed cuts included in the Medicaid Redesign Team's $2.3 billion cut. In that proposal, people with more significant disabilities are again disproportionately impacted by cuts that imprudently single out high cost people without any real analysis of the havoc those cuts will create. We will discuss what information we have about these additional cuts at tomorrow's DOH and Medicaid Fiscal hearing.

These proposed actions and cuts in the OPWDD budget appear to be of a magnitude that will jeopardize the agencies providing services to our most vulnerable New Yorkers. If the service providers are forced to close, NYS remains constitutionally

obligated to care for those with developmental disabilities who are dependants of the State. Historically, NYS itself provides these services at a much higher cost than the voluntary not-for-profit sector – NYS is in no position to take on this added expense.

These proposed cuts follow on the heels of a number of significant cuts we sustained in the current fiscal year (ending 3/31/11). Our day program services received an approximate 4% cut (this cut disproportionately singled out high cost transportation required by the more physically disabled), residential services received a 3% cut (again, people living in a certified residence are by definition more severely disabled than those able to live on their own in the community – a disproportionate cut), and our Medicaid service coordination programs took an 18% cut. Staff and services have been reduced as a result of these cuts. A cut beyond 2.7% this year exceeds the limit to what we might withstand – we will see our Affiliates severely reduce or even cut services in the next year. As a result, we seek your help in minimizing these cuts.

Since our voluntary not-for-profit agencies are so heavily dependent upon staff, when cuts to funding occur, there is a direct impact on employees. With our providers typically among the top five largest employers in each county of the State, these Medicaid cuts, as proposed, will have far-reaching impacts on unemployment levels across New York State. The same people who are employed in Medicaid-funded programs will find themselves on Medicaid, adding to NYS and county costs rather than employed taxpayers with health benefits.

Another fact we ask you to keep in mind is that for most CP providers, 90–100% of our funding is Medicaid. This means that a cut in Medicaid funding will have a greater impact on our operations than those with other sources of revenue, e.g., hospitals (statewide, less than 29% of their revenue is typically Medicaid). An 8% cut to voluntary, not-for-profit providers of services for people with developmental disabilities is like proposing a 24% cut to hospitals' Medicaid funding.

The Governor's budget ignores opportunities for revenue, such as the "millionaire's tax" which would generate $1 billion this year and $4 billion in annual revenue for the State. Further, the Governor's budget fails to preserve federal Medicaid matching funds – money that could be used to protect people with disabilities.

Over the years, CP of NYS Affiliates have become the providers who offer programs and services to those most unable to find services, be it residential, education, or health, in typical community settings. When you look at how close to the margin our organizations run, it is easy to understand the impact such things as rising food costs, heating and fuel costs, union salary obligations, the MTA tax, and other uncontrollable increases will have on our bottom line. The proposed cuts are worth more than the dollars in the budget because, like all New Yorkers, we face these everyday increased costs as well as additional taxes and assessments such as the 1.1% FMAP assessment and the additional MTA payroll tax.

Our Affiliates have been working together over the past few years to find efficiencies in their operations, generating ideas for reforming our service delivery models, and partnering with others to maximize our community resources. Many of these initiatives take time as well as support from State regulatory bodies – we are only now seeing real movement from the State in the form of regulatory relief, and it will take time for the savings to be realized. In the meantime, we look to you to help ensure that people are not harmed and the success of the past sixty years is not forsaken.

CP of NYS has gotten to where we are by partnering with NYS for more than sixty years, and we hope to be there for another sixty years for people with disabilities. With your support, we can work together to find efficiencies in the system without taking needed programs and services from people with disabilities. We are eager to redesign the system and services for people with developmental disabilities. But a system in crisis, which would result if you were to pass these unsustainable cuts, would be unable to move forward in redesigning the system.

Therefore, we ask you to consider the field's proposal which includes a 2.5% cut, increased assessment, and Health Care Adjustment which preserves federal funding.

We appreciate your consideration of our comments and look forward to working with you as we look to continue our work on behalf of people with disabilities in New York State.

Thank you.

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NAMI New York State
National Alliance on Mental Illness

TESTIMONY BEFORE THE JOINT MENTAL HYGIENE LEGISLATIVE BUDGET HEARINGS

March 2, 2011

NAMI-NYS President
Sherry Janowitz Grenz

Testimony Presented By:

Sherry Janowitz Grenz
President

Paul Klein
Program Director

Good afternoon. My name is Sherry Janowitz Grenz. I am President of the National Alliance on Mental Illness-New York State (NAMI-NYS). With me is Paul Klein, our Program Director.

NAMI is the largest family and consumer grassroots organization in the country with 58 affiliates in New York State alone. We offer support, education, and advocacy for family members of those who have serious mental illnesses, as well as for those who suffer with mental illness themselves.

We are grateful to the members of the New York State Legislature for their steadfast support over the years. We especially want to recognize Assemblyman Felix Ortiz, Senator Roy McDonald, and OMH Commissioner Michael Hogan for their dedication and commitment to our cause. They are compassionate and effective leaders and we truly appreciate all that they have done---and continue to try to do--to make the world a better place for those suffering with mental illnesses. We would also like to acknowledge the previous Assembly Mental Health Chair, Peter Rivera, who we could always depend on and of course the late Senator Thomas Morahan, who was a tremendous voice for those living with mental illness. We urge you to continue his legacy.

Of New York's approximately 19.5 million residents, close to 673,000 adults live with serious mental illness[i] and about 204,000 children live with serious mental health conditions.[ii]More than 1.4 million New Yorkers have co-occurring mental health and substance use disorders.[iii]In 2007, 1,396 New Yorkers died by suicide.[iv] Mental health diagnoses are generally associated with a higher rate of suicide. Suicide is the eleventh-leading cause of death overall and is the third-leading cause of death among youth and young adults aged 15-24.[v] Fifty percent of people with co-occurring mental health and substance use disorders receive no treatment, while only 10% receive evidence-based treatment for both conditions.[vi] During the 2006-07 school year, approximately 50 percent of New York students aged 14 and older living with serious mental health conditions who receive special education services dropped out of high school.[vii]In New York, a study of 10,000 homeless people found that homeless persons living with mental illness cost $40,449 per person in publicly funded services a year for use of emergency rooms, hospitals, shelters and incarceration.[viii]

This is why it is critical to maintain the current level of funding for services that assist those with mental illness and the research that we pray will eradicate mental illnesses and save lives. We also urge New York to invest in several initiatives that would not only benefit those with mental illness but also have the ability to ease New York's financial burden moving forward.

NAMI-NYS has a wide range of issues that need to be addressed. However---out of respect for time--and out of recognition for the financial challenges New York State is facing we've decided to focus on just a few of those issues.

NAMI-NYS's priorities are:

1) The Need to Invest in Safe and Affordable Housing for People With Mental Illness
2) A Regional Managed Behavioral Health Care Coordination Initiative with Open Access and Increased Oversight for Medicaid Mental Health Medications
3) The Need for Government Sponsored Research of Mental Illnesses
4) The Support of Veteran's Mental Health
5) Implementation of the SHU Exclusion Bill
6) The Inclusion of Mental Health Education in Schools

1-The Need to Invest in Safe and Affordable Housing for People With Mental Illness:

Ever since NAMI-NYS was incorporated in 1982, safe, affordable housing has been an ongoing priority of ours. A stable environment is vital and fundamental to people living with serious mental illness. In 2007, the Campaign for Mental Health Housing called for a multi-year commitment to having 35,000 additional housing units built in New York State. Only 14% of people with serious mental illness had access to state assisted housing; one third were living with families; and the rest in state psychiatric centers, adult homes, jails, prisons, shelters, and in the streets.

The New York/New York III program promising 5,500 housing units designated for those with mental illness over a 10-year period falls seriously below the actual need and is fraught with development delays and setbacks.

The number of mentally ill persons housed through OMH, including 7,000 units that are still in development is 40,000. This simply does not provide enough affordable housing.

Access to decent, safe, and affordable housing remains a tremendous challenge for adults with severe mental illnesses. Many people with the most severe and disabling mental illnesses also need access to appropriate services and support so they can successfully live in community-based housing, which promotes their independence and dignity.

The government's budget problem is a health care problem, and housing is a solution to the health care problem. By providing decent, safe, affordable housing to needy populations, we provide a base of stability that allows us to provide in-home services at a small fraction of the cost (and usually with better outcomes for the client) compared to institutional care. By starting with housing, we can often save tens of thousands of dollars per year in avoided Medicaid costs, ambulance fees, emergency room visits, and other care.

- 25 percent of people who are homeless suffer from some form of severe and persistent mental illness, compared to 6% of the entire population that suffers from a mental illness.
- All people with mental disorders, including those who are homeless, require ongoing access to a full range of treatment and rehabilitation services to lessen the impairment and disruption produced by their condition.
- Most people with mental disorders do not need hospitalization, and even fewer require long-term institutional care.

This is why NAMI-NYS urges New York to create more safe and affordable housing for people living with mental illness.

NAMI-NYS also recommends a "New York/New York IV agreement" for 4,000 units per year for three years. This would supply supportive housing for a growing number of homeless people living with mental illness who are on the streets and in shelters in New York City, with funding to begin in 2012.

NAMI-NYS Urges New York State to Comply Fully with Adult Home Federal Court Ruling

A recent federal court ruling found that New York State was in violation of the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's Olmstead decision by unnecessarily segregating many adult home residents with psychiatric disabilities. The court determined that adult homes are "segregated institutional settings that impede

integration in the community and foster learned helplessness."

New York State must not appeal or delay its responsibility to provide appropriate housing and supports to adult home residents who choose to, and are able to, move into the community. This would also reduce reliance on costlier Medicaid services.

Mentally ill people transitioning out of jail and forensic units at state hospital facilities are in dire need of supervised housing. Without appropriate housing in place, recidivism is especially high within this population.

Please maintain funding to provide housing and services for the seriously mentally ill who do not have the financial resources to afford the most basic human need...that of a safe, accessible, stable and affordable place to call home.

2- **A Regional Managed Behavioral Health Care Coordination Initiative with Open Access and Increased Oversight for Medicaid Mental Health Medications**:

Last week, the Medicaid Redesign Team appointed by Governor Cuomo submitted a plan on how the Medicaid system should be modified to be more fiscally responsible. Mental health advocates, including NAMI-NYS, agree that the best alternative on the table is a separate behavioral health managed care plan, called a "carve-out plan".

NAMI-NYS supports Governor Cuomo's Medicaid Redesign Team's "carve-out" proposal. This proposal will integrate and improve the coordination of behavioral health (mental health and substance use) services and link them to appropriate health, housing and support services.

A carve-out model will ensure Medicaid mental health dollars would be managed by specialized health care providers that understand the complex needs of people with serious mental illness. A carve out will give behavioral health advocates and providers a say in restructuring outpatient care management and rehabilitation services to improve the quality of care. This will decrease the need for inpatient and emergency services and in turn save the state money. That's the kind of reform that NAMI and its members can support.

A carve-out model is critical to ensure that individuals and their families get access to quality mental health services. It will ensure that our loved ones will receive the most effective and focused care possible from specialized doctors.

However, NAMI-NYS is concerned about two proposals being considered as part of New York's Medicaid redesign. We oppose making certain antipsychotic medications subject to a prior authorization requirement. We also oppose lifting the "prescriber prevail" protections that are currently in place.

NAMI-NYS wants a plan with open access and increased oversight for Medicaid mental health medications.

NAMI-NYS supports unrestricted access to evidence based psychiatric medications and opposes the proposal to eliminate fee-for-service reimbursement for pharmacy and their "carve in" into managed care plans.

3-**The Need for Government Sponsored Research of Mental Illnesses**:

For those living with severe persistent mental illness and their families, research is our hope for the future. NAMI-NYS strongly supports efforts to maintain and eventually increase state funding to ensure there are adequate resources for promising biomedical research into brain disorders.

I have long testified that "Research is our hope for the future"; but the truth is: The "future" is now. Mental health research in New York State has real and measurable effects today. For example: OMH's Center for Practical Innovation "brings research into practice". CPI has taken the lead on improving the delivery of care, training practitioners around the state and promoting recovery through consumer-based initiatives. Innovations such as these improve quality of life and reduce health care costs today by replacing less effective treatments with treatments we know work.

According to a recent study conducted by the World Health Organization, no less than four of the top ten causes of disability worldwide are severe mental illnesses. Major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder account for an estimated 20 percent of total disability resulting from all diseases and injuries. Based on National Institute of Health's own estimates, for every research dollar spent, 15 cents is allocated to AIDS, 10 cents on cancer, two cents on heart disease, and less than one cent on schizophrenia and other severe mental illnesses. In contrast, the total cost of schizophrenia to society, per research dollar spent, is $161.26, compared to only $65.65 for heart disease, $9.96 for cancer, and $6.86 for AIDS.

New York is fortunate to have two leading research facilities, New York State Psychiatric Institute in Manhattan and Nathan Kline Institute in Rockland County. Their world-class doctors are making strides and breakthroughs every day, but we still have a long way to go. Medical science has yet to produce cures for severe mental illnesses. Furthermore, the most promising evidence-based treatments and services remain inaccessible for people who need and deserve them. From biomedical research to services research, NAMI-NYS believes that research on severe mental illnesses are underfunded.

Research paves the way for prevention, recovery, and cure. Through research we obtain better value for our healthcare dollars by bringing more effective treatments to the people who need them. The road from science to service must be well traveled to ensure accountability and promote evidence-based treatments. Without research, treatment stagnates, and our loved ones languish with expensive yet suboptimal care.

Researchers at NYSPI conduct comparative effectiveness research to evaluate the value of new treatments and unproven strategies. This work provides the evidence on which clinicians and policy makers base decisions. The Center for Practice Innovations disseminates and implements evidence-based practices to improve quality and value in our public mental health system.

Racial, ethnic and socioeconomic disparities characterize access to and utilization of mental health services. Research identifies barriers to good care and develops and tests interventions to promote access and culturally competent care

We must continue to invest in the crucial research being performed at NYSPI and NKI.

REASEARCH IS OUR HOPE FOR THE FUTURE

4-Support Veteran's Mental Health

Supporting those who have served our country must always be a top priority. NAMI-NYS believes this and calls on the Legislature and the Governor to assist veterans on all issues, but specifically those relating to mental health.

Returning combat veterans are experiencing very high rates of serious mental illness, suicide, addiction, homelessness and incarceration related to posttraumatic stress disorder. More must be done in New York to provide services to

America's returning heroes of combat.

- Nationally, 20% of returning veterans live with post-traumatic stress disorder, but only half seek and receive treatment for this
- This means of the almost one-million veterans living in New York State, approximately 100,000 are not receiving necessary treatment. Clearly, this is not acceptable, and reform must take place to improve the access and affordability of mental health services for veterans
- The VA estimates that nationally there are 107,000 veterans homeless on any given night. Most of these suffer from PTSD or another serious mental illness. (Of all homeless men, it is estimated that 40% of them served in the armed forces)

NAMI-NYS urges the passage of Assembly Bill A00682. This initiative will require the New York State Veterans' Affairs Commission to develop and update, in consultation with the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, Department of Health and Department of Labor, a New York state interagency plan to improve outreach, assessment, and care for veterans and their families who are experiencing mental health and/or substance abuse problems.

Increase funding for mental health and medical treatment for veterans with serious mental illness. Although funding for mental health treatment has increased in recent years, significant numbers of veterans with serious mental illness are still falling through the cracks because they are not getting the services they need. Ensure that monies designated for mental health and substance abuse treatment for veterans are allocated to Veterans Medical Centers, Community-Based Outpatient Clinics (CBOCs) and other programs serving veterans with mental illness and utilized for the treatment of these individuals.

We have a moral obligation to provide our veterans the best and most readily available services we can offer.

5-**Support the Implementation of the SHU Exclusion Bill**:

In 2008, New York State enacted the SHU Exclusion Law stating people with serious mental illness who are incarcerated and sentenced to more than 30 days disciplinary confinement have to be held in a mental health unit and not placed in SHU (Special Housing Unit), also known as solitary confinement, "The Box", and Keeplock. Placing an inmate with mental health issues in SHU adds to decompensation and increases their risk for suicide by 50%.

Corrections personal are required to base decisions concerning treatment and conditions of confinement on the person's therapeutic needs, as well as the unit's safety and security requirements. People placed on mental health units must be offered at least four hours out-of-cell programming and/or mental health treatment every weekday.

Ideally mentally ill prisoners would be better off not in solitary confinement at all since solitary confinement is toxic to their health. Unfortunately this law does not provide for that. The New York State Department of Corrections (DOCS) can still keep a mentally ill prisoner in SHU if there are "exceptional circumstances." The SHU Bill also provides for:

- Training for DOCS staff on mental health issues
- Periodic mental health assessments of people confined in SHU
- Limitations on the use of the restricted diet penalty
- Authority for Commission of Quality of Care and Advocacy for Persons with Disabilities (CQCAPD or

CQC) to monitor prison mental health care

Implementation of the SHU bill is critical to ensure people with mental illness, who are incarcerated, receive the proper care for their mental illness, thereby not exacerbating the symptoms and causing a cycle of in and out of SHU due to psychotic breaks.

It is imperative that CQC oversee the implementation of the SHU Bill.

The SHU bill should be fully implemented in all New York State prisons no later than July 31, 2011.

6-**Mental Health Education in Schools:**

Education, early intervention and working on preventions are keys to minimizing and hopefully, eventually eradicating mental illnesses.

It is vital that New York's education system do a better job of creating awareness of mental health issues and warning signs so administrators, teachers and students have a true comprehension of mental health. Mental health education should be integrated into our educational curriculums. This will allow for better recognition of mental illness which will lead to our children getting the proper support they need as well as s reduction in harassment and bullying which can excel mental illness and contribute to an already high suicide rate in adolescents.

- 10% of American youth suffer from serious mental health conditions
- 50% of mental illnesses develop by age 14, 75% by age 24
- 70-80% of children living with mental illness do not receive needed treatment. This leads to decreased performance in schools
- 2.2 million adolescents aged 12 to 17 have experienced a major depressive episode in the past year and nearly 60% of them did not receive any treatment
- The dropout rate for children with severe emotional health and mental health issues is twice that of other students
- Expanded school mental health services in elementary schools have been found to reduce special education referrals, improve aspects of the school climate and produce declines in disciplinary referrals, suspension and grade retention

One initiative that demonstrates the impact of incorporating mental health education in schools is NAMI Queens/Nassau's *Breaking the Silence* program. Breaking the Silence…

- Destigmatizes mental illness via in-class education
- Provides 4-12 curriculum and lesson plans
- Warning signs, tolerance, anti-bullying, and character development are taught.
- Fulfills national health education standards
- Qualitatively shown to increase knowledge, awareness, and attitudes of mental illness and health.

NAMI-NYS urges New York to fund the incorporation of mental health education in our schools.

Our goal is to PROTECT and PRESERVE what we have; our hope is to PROGRESS and PROVIDE...for the present and for the future. You have come through for us in the past, we are counting on you to come through again. Thank you for listening...and thank you for caring.

NAMI-NYS IS COMMITTED TO THE ELIMINATION OF DISPARITIES IN MENTAL HEALTH CARE FOR DIVERSE COMMUNITIES AND IS COMMITTED TO CULTURAL COMPETENCE IN RESEARCH, TREATMENTS, AND SUPPORT.

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[iv] McIntosh, J. L. (for the American Association of Suicidology). (2010). U.S.A. suicide 2007: Official final data. Washington, DC: American Association of Suicidology, dated May 23, 2010, downloaded from http://www.suicidology.org.

[v] National Institute of Mental Health, "Suicide in the U.S.: Statistics and Prevention," 2009, http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml, (January 25, 2010).

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[vii] U.S. Department of Education, Office of Special Education Programs, Data Accountability Center, Individuals with Disabilities Education Act (IDEA) Data, "State Rank-Ordered Tables," Table 1.3b, Data Analysis System (DANS), (July 15, 2008), https://www.ideadata.org/StateRankOrderedTables.asp.

[viii] Kupersanin, E., "Getting Homes for Homeless is Cost-effective," *Psychiatric News*, (June 1, 2001).

TESTIMONY PRESENTED BY

DONN ROWE

President

New York State Correctional Officers & N.Y.S.C.O.P.B.A. POLICE BENEVOLENT ASSOCIATION INC.

March 2, 2011

Testimony of Donn Rowe

New York State Correctional Officers and Police Benevolent Association, Inc.

March 2, 2011

Good afternoon Chariman DeFrancisco, Chairman Farrell and Members of the Legislature. My name is Donn Rowe and I am President of the New York State Correctional Officers and Police Benevolent Association (NYSCOPBA). NYSCOPBA represents more than 23,000 active and retired critical law enforcement personnel, including the Safety and Security Officers (SSO) and Security Hospital Treatment Assistants (SHTA) who provide an invaluable public service by ensuring the security and safety of New York's psychiatric hospitals and other mental health facilities.

On behalf of all our members, I would like to thank you for the opportunity to testify here today and to voice our members' serious concerns with the Executive Budget proposal from the New York State Office of Mental Health.

We firmly believe the Executive Budget proposal, if enacted as currently written, will have unjust and harmful impacts on the men and women and their families who put their lives in danger every single day.

Specifically, this proposal will eliminate the one-year notification period of any significant reduction in services or closures that currently exists in the State's Mental Hygiene Law. These changes will add unnecessary duress to the employees, their families and undermine the units' abilities to attract and recruit qualified recruits. In a line of work that has very little security or stability, the very least we can do is ensure they have a reasonable understanding for potential changes to their position.

Under the proposed law, the thousands of men and women who currently hold these dangerous and extremely challenging positions would not only have to watch out every day to being injured on the job, they have to watch every day to see if their families and their lives will be upended in a matter of 24 hours. The uncertainty of one comes with the job, the uncertainty of the other is cruel and will do untold damage to our units and their families.

The way it would be structured, in a matter of 24 hours my officers' lives and their families' lives could be completely turned upside down. These individuals and their families would have obsoletely no warning or recourse if their superiors decide to relocate them or terminate their position. In an instant these men and women would be forced to pick up and move, uprooting their families and disrupting their communities.

In fact, it's quite possible that officers could be moved repeatedly, creating a transient group of security personnel who are forced to bounce from one facility and one community to another. This stress and uncertainty is simply not sustainable. This is not

only unjust, it is counterproductive and will result in the loss of talented men and women who have decades of experience and knowledge in how best to handle some of the State's most volatile and violent offenders.

After all, let's be clear about what these men and women do every single day to help keep our communities safe. The offenders sent to these facilities are the ones deemed unfit to be sent to our traditional prisons. These are often violent offenders who are psychologically unstable and easy unnerved. These are people who can no longer exist in public society because of their actions and their mental state. These are also people who will often act out and become extremely difficult and potentially violent.

It is my group who are hired to help manage and control these offenders. These security personnel often have to handle and transport those offenders by cajoling, calming and, when necessary, forcibly moving them. They are also the ones called when there is a problem, or worse, when a problem has become a crisis. Every single day can become a minefield and warzone for our men and women.

Physically restraining and controlling these offenders can be an extremely challenging and difficult proposition. Often my men and women are injured in the job. We do not complain, we know it comes with the territory. We are hired to do a job and we do it well.

All that we ask in return is to have a job to return to each day and to have some stability in which to grow and support our families and communities we live in. The repeal of the one-year notification will throw a huge amount of uncertainty into a job that already is ripe with great unknowns.

To treat these men and women with such disrespect and without any regard to their wellbeing or their families' wellbeing is beyond reproach. These are not simply budgetary numbers; these are people with families and lives. They are also the men and women who safeguard the staffs and facilities.

We all know and recognize that the challenges of this year's budget. Faced with a daunting budget shortfall and the need to make more out of less, there is no doubt that cuts must be made, spending must be reeled in and new cost saving measures must be employed. We understand and agree with this sentiment.

However, to throw the hard working men and women who serve to protect the lives and safety of these facilities into what would amount to utter chaos will have very serious and far reaching negative implications and ultimately undermine the safety of our facilities and surrounding communities.

We implore you not to accept the changes in the one-year notification and seek to find a better way to protect the men and women who protect us all.

Thank you for providing me with the opportunity to testify in front of you today. I would be happy to address any questions you may have or to continue this dialogue on these crucial matters at any time or place in the near future.

294 Bay Rd
Queensbury NY 12804
518-798-1100 Fax 747-798-1104
www.voicesoftheheart.net

Dear Senator DeFrancisco

Voices of the Heart, Inc. is a non-profit organization operated as a peer support center offering self-help/mutual support, advocacy, training, and a hospital crisis diversion support/peer respite house. (please see attached newspaper article from Medicaid hearing)

Please accept this written testimony, Voices of the Heart, Inc. submits the testimony as to the request to separate Mental Health PEER Support from any Medicaid billing structures.

Voices of the Heart, Inc operates a unique support/program our "Peer Respite House/Hospital Diversion Support". Peer – run respites operate on values of mutuality, self-determination, healing in relationship, co-expertise. Imbedded in these values are principles of trauma sensitivity, accessibility, and a fundamental belief in the probability for a person to move forward. These Values and Principles rely on the power of relationship, the wisdom gained through lived experience, and the importance of building a sense of community in which each person has a valued role.

In contrast Medicaid practice would create a hardship for independent peer operated non - profits. Medicaid requirements are inconsistent with the fidelity to the peer support model. Peer Support practices have been developing over many years, in areas within and beyond mental health, and there are certain principles and values that are the cornerstone of peer practice, with a significant body of evidence to demonstrate the effectiveness and necessity for the core components.

Please find our attached newspaper article, which shares some basic economics as to how Voices of the Heart, Inc. "Peer Respite House/Hospital Diversion Support" offers economic savings. Peer Support allows economic savings standing alone, without the intervention of a Medicaid billing system.

Voices of the Heart, Inc. would like to thank you for the opportunity to share our organizations experiences and testimony. Please feel free to contact Voices of the Heart, Inc. to visit our community offered supports.

Sincerely,

Daniel Hazen
Executive Director
Voices of the Heart, Inc.

The Post-Star

Voices of the Heart program seen as example of alternative to costly hospitalization

By MAURY THOMPSON thompson@poststar.com | Posted: Saturday, February 12, 2011 12:00 pm

A locally-based program that provides short-term housing to individuals experiencing mental health crisis, as an alternative to hospitalization, could be a model as the state looks to redesign the Medicaid program, said Daniel Hazen, executive director of Voices of the Heart.

The nonprofit organization, among other services, operates a "peer respite program" in Hudson Falls, essentially a 2-bedroom apartment, that provides services to residents of Warren and Washington counties.

Someone in crisis can call 798-1100 to talk with a staff member, and if necessary the staff member will arrange for the individual to come to the respite house.

The respite program provides services for about $250 per person per day, compared with $1,200 to $1,400 if the same person went to a hospital, Hazen told Gov. Andrew Cuomo's Medicaid Redesign Team at a public hearing at Adirondack Community College last week.

The hospital estimate includes the cost of ambulance transportation, an emergency room visit and an overnight stay, Hazen said later.

A heavy reliance on hospital care for the mentally ill is among the reasons Medicaid costs in New York are so high, said Harvey Rosenthal, executive director of New York Association of Psychiatric Rehabilitation Services, an advocacy organization.

The Medicaid program now spends about $1,400 per member per month for chronic medical and mental health conditions, according to the state Department of Health.

Mental health is one of the higher cost areas that certainly will need to change the way services are provided, said Medicaid Director Jason Halgerson.

Hazen said the local respite program costs less and is more personalized than receiving care in a hospital.

"We're offering people care at lower cost but really connecting with the person in a different way -- a holistic way, every part of their life," he said.

People typically stay anywhere from three to 15 days at the local respite house, which is funded with a $283,000 annual state grant and about $17,000 in local charitable contributions.

It is one of only two such programs in the state and only nine in the nation, he said.

Hazen said the reason there are not more of these type programs is because the funding is limited.

If the state directed more money to programs like his, it would save the state money, overall, he said.

David Kruczlnicki, president and chief executive officer of Glens Falls Hospital, said he was not familiar specifically with the local peer respite program, but said reducing the frequency of hospital emergency room visits is one of the goals of redesigning Medicaid.

Another goal, Rosenthal said, is to enroll more mentally ill recipients in Medicaid managed care plans.

Rosenthal urged the panel to enroll recipients in specialized managed care plans, called "behavior health management organization," rather than traditional HMOs.

"And so we accept that it has to be managed now. But we think we should be managed under the supervision of the agencies that know us best," he said.

Kruczlnicki said the Medicaid program could save money and increase efficiency by consolidating state agencies.

"Specifically in the area of mental health and behavioral health services there is a number of redundant bureaucratic layers," he said. "We believe it makes sense to consolidate the Office of Mental Health, the Office of Alcohol and Substance Abuse Services, and Office of Persons with Developmental Disabilities into the Health Department in the interest of efficiency and reduced redundancies."