

New York State  
Office of Mental Health

# 2008-2009 Executive Budget Testimony

January 29, 2008

New York State  
Eliot Spitzer, Governor

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





**G**OOD AFTERNOON Senator Johnson, Assemblyman Farrell, members of the Legislature, Colleagues and Guests. Thank you for your interest and leadership, and your collaborative efforts to work with us to strengthen mental health care in New York.

Despite difficult fiscal circumstances shaped by a struggling national economy, this is a good budget for mental health, building on the extraordinary support that Governor Spitzer and the Legislature provided in the last budget. Before turning to a discussion of proposals for FY 2008–2009, I would like to set the stage by reviewing issues and needs in mental health. I also have now had the benefit of a year to speak with hundreds of people and visit dozens of programs and communities across the Empire State. A year is not enough to fully understand the most complex, and one of the largest mental health systems in the world. But it is enough to assess some of the issues and concerns that we must recognize, and address together.

The mission of the Office of Mental Health (OMH) is shaped by the nature and scope of mental illness, and the historical and statutory framework for mental health care in New York. Mental illness is prevalent and disabling – although highly treatable. One in five Americans experience a diagnosable mental disorder annually; one in ten experience an illness serious enough to impact their life at home, school or work.

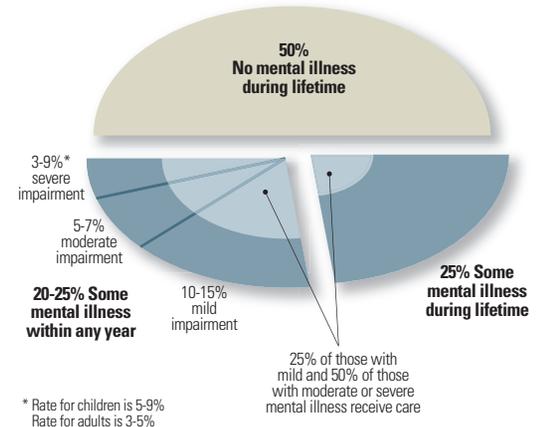
Yet less than 50% of those with serious disorders receive any care. As a result, mental illness is the leading illness-related cause of disability, a major cause of death (via suicide), and a driver of school failure, poor overall health, incarceration and homelessness.



*The State Lunatic Asylum at Utica, New York circa 1885.*

The mental health responsibilities of New York State government trace to 1836, when the Legislature authorized construction of the state’s first mental health facility (the “State Lunatic Asylum” at Utica). In 1873, the Office of State Commissioner in Lunacy was created and licensure of public and private mental health institutions was required. The Department of Mental Hygiene was created in 1926. In 1954, in the first such law in the country, the Legislature

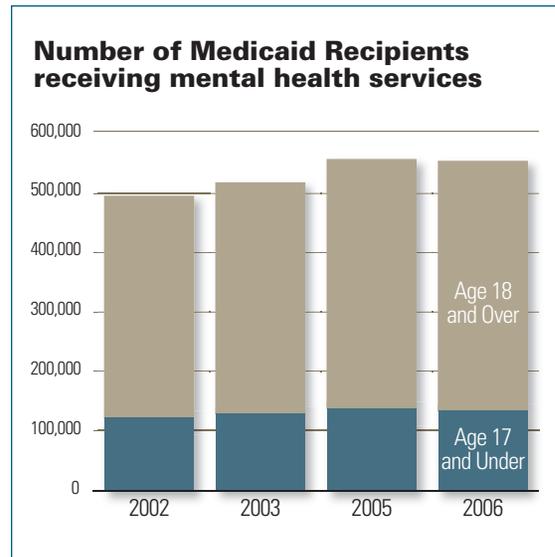
### Patterns of mental illness and mental health care



### The ten leading causes of years lived with disability in 1990 according to the Global Burden of Disease Study

1. Unipolar major depression
2. Iron deficiency anemia
3. Falls
4. Alcohol use
5. Chronic obstructive pulmonary disease
6. Bipolar disorder
7. Congenital anomalies
8. Osteoarthritis
9. Schizophrenia
10. Obsessive-compulsive disorder

established local community mental health boards. In 1978, the Department was divided into Offices of Mental Health, Mental Retardation and Developmental Disabilities, and Alcoholism and Substance Abuse Services.



This context and brief history illustrate how OMH is responsible for a long-standing, state/local and public/private safety net for mental health care. While most New Yorkers who receive mental health care do so in private settings (from therapists, hospitals) paid by health insurance, the OMH safety net—public and private, State and local – serves over 600,000 individuals annually. Of those served, about 356,000 have the most serious and persistent illnesses and disability, and about 140,000 to 156,000 are children. The mission of OMH, reflecting its broad responsibilities and its safety net focus, is: to promote the mental health of all New Yorkers with a particular focus on providing hope and recovery for adults with serious mental illness and children with serious emotional disturbances.

## The Challenges We Face

The challenges we all face to improving mental health care emerge from several factors: the realities of serious mental illness, the fact that many individuals lack adequate insurance, the complex and fragmented nature of New York’s mental health system, and problems in financing care. Also, the scope of mental health problems extends far beyond the OMH-coordinated system.

The most recent research concludes that the average age of onset of a mental illness is 14 years, while the average delay from first symptoms to receiving care is nine years. It is tragic that in the 21<sup>st</sup> century, a young person becomes ill and doesn’t receive care for nine years. The delays are due to a failure to recognize symptoms, the stigma of seeking care, challenges in finding care, a fragmented system and the lack of insurance coverage. These problems result in mental illness negatively impacting families, businesses (where depression alone causes annual produc-

tivity losses of over \$40 billion) and the systems we have in place to provide services like Education, Children and Family Services, Corrections and society as a whole.

I can tell you from personal experience that these challenges exist in many states. But New York State faces the additional challenges of a large and an exceptionally decentralized and fragmented approach to care. There are major state responsibilities in OMH and DOH, county government responsibility in 57 local governmental units including New York City, and care delivered by over 2,500 licensed private agencies. OMH operates the nation's largest network of state-operated facilities, functioning as a kind of "safety net within a safety net" for individuals with the most serious conditions. In this complex and scattered system, no one entity is responsible for any individual's care.

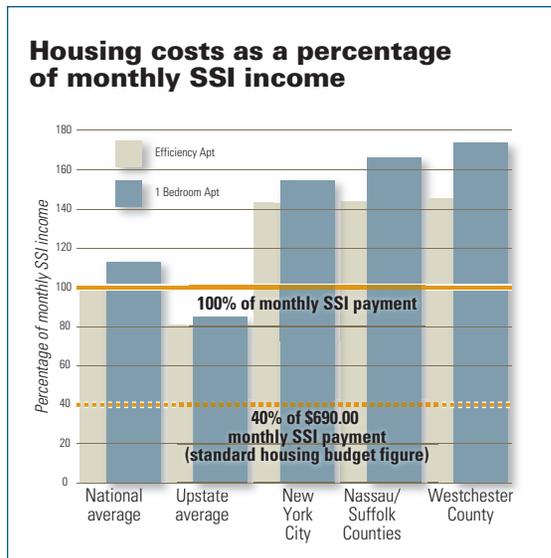
**O**NCE UPON A TIME, responsibility for people with serious mental illness was focused and manageable. The State's responsibilities consisted of running institutions, financed almost 100% with state funds. With a move to community care and a "devolved" approach, people with a mental illness and indeed most mental health programs depend largely on mainstream benefits and programs (e.g., Medicaid and Medicare). In many cases these programs are not well aligned with the requirements of good mental health care. A national perspective on mental health care, to use the title of a recent book by Drs. Sherry Glied from Columbia and Richard Frank from Harvard, finds that the status of people with a mental illness is "Better, but not well." Benefits – mostly in major federal programs like Medicare, Medicaid, and Social Security – have somewhat improved the well-being of people with a mental illness, but they have helped make the "mental health system" amorphous and virtually unmanageable.

The limits of these federal programs create serious challenges in transforming the system of care. Medicaid has become the nation's largest payer for mental health care. Created originally without any mental health benefits (and in fact with some stringent prohibitions against paying for mental health care), Medicaid slowly added coverage for mental health treatment. In response, to finance mental health care, New York aggressively captured Medicaid dollars. The fit is uneasy; many persons dependent on the OMH network are not Medicaid eligible, many essential services (e.g. employment, housing) are not covered by Medicaid, and Medicaid is governed through complex



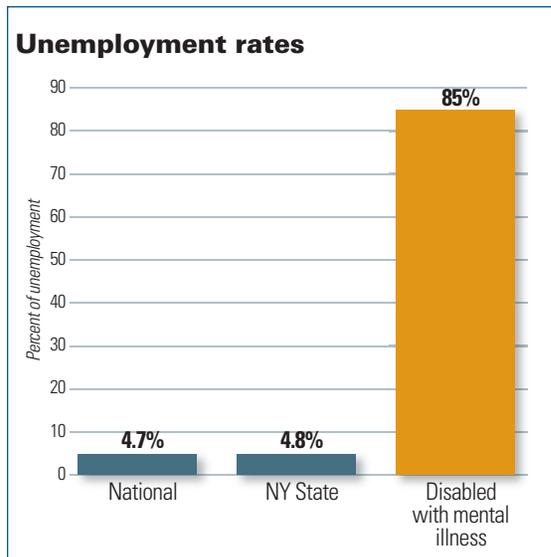
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and slow-moving regulatory processes—exacerbated by federal-state tensions. Currently we are very fortunate to have a genuinely collaborative relationship with State Medicaid Director Deborah Bachrach. Even with shared goals and commitments, we are working hard to overcome the problems and inequities embedded in Medicaid financed mental health care.

New York and the nation also face a crisis in affordable housing. Many factors contribute to this problem. The federal government has virtually abdicated a low-income housing development role. Distress in the housing finance marketplace and gentrification across New York City make our challenge much harder. New York has the highest proportion of renter-occupied housing of all the states, very high housing prices, and large numbers of poor people with disabilities who live in communities where housing is expensive. Therefore, New York State (especially in the Metro NYC area and on Long Island) is the epicenter of a national mental health housing crisis. By my calculation, more people with mental illness and low income live in this high-housing-cost area of New York State, than in all the other similar areas in the U.S. combined!



In this context, we are deeply appreciative of the leadership and vision that Governor Spitzer has provided with his proposal to create the *Housing Opportunity Fund*. It signals a recognition that safe, decent and affordable housing is the foundation of a good life, and that supported housing is an essential and mainstream element of good care for people with disabilities including mental illness.

Schools face serious challenges among students whose mental disorders create learning and behavior problems. Between 5–9% of children have a mental illness significantly impacting behavior, but only 1% of students receive special education services as “emotionally disturbed.” Sadly, these children have the worst outcomes among children in special education.

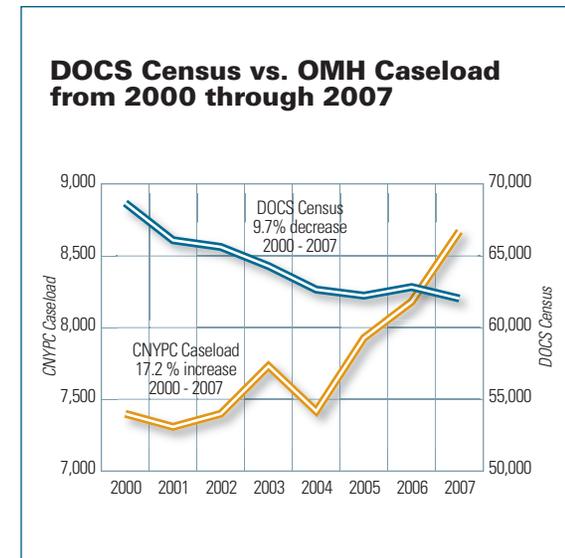
Unemployment is a fact of life for most individuals with a mental illness. Although most would like to work, 85% of adults receiving mental health care in New York are unemployed. Reliance on Medicaid has contributed to a shortage of mental health employment services. People with mental health conditions are the largest disability group entering vocational rehabilitation, but have the worst outcomes. Mainstream employment services often do not have

the expertise to assist their mentally ill clients. Stigma plays a crippling role when people look for work. The fear of losing benefits – and perhaps our desire to keep people in treatment programs and to shield them from risks – contribute to this unacceptable situation.

Law enforcement, courts and corrections agencies are struggling to deal with mentally ill offenders. Periodic reports of police difficulties in dealing with mentally ill persons illustrate these challenges. Challenges in our prison system are a reflection of community problems. In New York's adult prison system the population receiving mental health care has almost doubled to approximately 8,400 prisoners in the past 17 years, while services have been enriched and improved – and are now more comprehensive than in most New York communities. In the past several years the number of inmates overall has declined while the number with a serious mental illness has increased by 17%. In the juvenile system, research establishes the prevalence of mental illness at about 66%.

These patterns illustrate the challenges in improving mental health care for New Yorkers. The scope of mental health problems extends far beyond the OMH-coordinated system. Yet in mainstream settings where mental disorders should be better addressed (e.g. primary care, early education, schools, employment programs) there is little awareness or capacity to deal with the challenges of mental illness. These problems are more serious where community needs and problems are unique and sometimes greater, especially in inner cities and in rural areas. When people do not get early assistance and preventative treatment, problems are exacerbated and the overburdened mental health safety net must respond.

**A** SECOND MAJOR CHALLENGE we face after we confront the size, complexity and decentralized nature of mental health care is that the effectiveness of New York's mental health system is compromised. Over-reliance on Medicaid financing has created gaps in care and has skewed priorities. The operating systems within New York State government (e.g. budget, human resources, purchasing, capital) are complicated, redundant and centralized thus making change exceptionally difficult. These complexities are magnified in the case of OMH's health care facilities, operating on a 24/7 basis to provide care that meets federal and state accreditation requirements.



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Historically, and even with significant reductions over the past decades, New York is over-reliant on expensive inpatient care. Yet providers and families complain that access to inpatient care is poor. We face a paradox: access to inpatient care is frequently problematic despite a high supply of beds because lengths of stay are excessive. Hospital stays are often too long because of gaps in both access and coordination of care. The weaknesses in the overall system lead to high costs, poor access, and frustrations for consumers, families and clinicians.

Continuity of care is a major challenge in New York. Individuals can be served by multiple community agencies, where no one agency or entity has overall responsibility to step in when problems emerge. On leaving Medicaid-paid inpatient care in hospital psychiatric units, less than half of all individuals complete a public Medicaid reimbursed outpatient visit within a month. This leads to an expensive, disruptive and inefficient “revolving door” problem; 20% of all people discharged are readmitted to inpatient care within a month.

Finally, inattentiveness to coordinating care and policy between agencies has reinforced barriers to care. In the *People First Listening Forums* conducted by Governor Spitzer’s health commissioners, many agreed that access to care for consumers is more difficult and requires more assistance when one has multiple needs.

Given these challenges, our priorities must be realistic and focused. We have much to build on and sustain; a progress report on OMH activities over the past year includes many highlights.

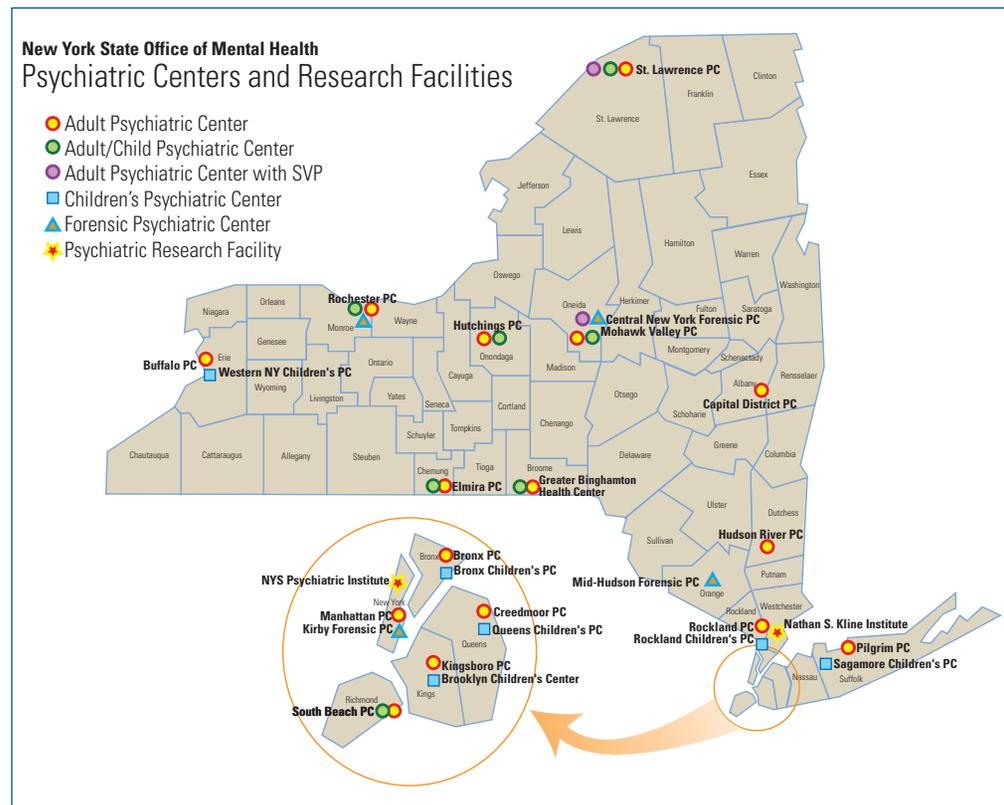
## Reforming Ambulatory Mental Health Services

- ◆ *We brought together stakeholders* (providers, consumers, advocates, researchers, and others) from across New York to discuss the best methods of restructuring OMH’s outpatient mental health payment system. With support in last year’s budget appropriations, a report was commissioned on the system’s structural problems and recommendations for rationalizing payment mechanisms. Despite relatively high resource levels, access to the most inexpensive level of mental health care (visiting a clinic to see a doctor or therapist) is

poor, with waiting lists commonplace. Problems include an outdated and inequitable payment system that creates barriers to expanded care, inadequate reimbursement levels for basic treatment, and regulatory barriers and inconsistencies between and among state agencies. As a follow-up to the response, OMH has facilitated numerous working sessions over several months to map out a plan for reform and is working with shareholders and other State agencies (especially DOH and OASAS) to simplify, streamline and improve both regulation and reimbursement. The proposed budget makes significant first steps to improve access to and equity in clinic care.

◆ *We launched steps to revitalize OMH adult Psychiatric Centers (PC's).* OMH operates 25 facilities and two research facilities, with a total of about 5,500 beds for inpatient care and extensive outpatient services in communities across New York and in the prison system. The forensic (court and corrections-related) and children's hospitals are generally "doing the right thing right" with a focus on urgent and in many cases, relatively short inpatient care backed up by community treatment and support. The adult hospitals are the largest component of this system, with about 4,000 beds and an excellent network of intensive community care. However, the inpatient system has become largely inaccessible because discharges are slow. In 2005, this 4,000 bed system accepted only 3,700 admissions.

To meet community needs, the adult PC's should move toward more accessible, shorter stay treatment and expanded provision of intensive community services – within approximately constant resource levels. This grad-



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ual process will start by finding or creating more appropriate settings for long-stay patients who need intensive, but not hospital level care and whose disabilities are in part, the result of lengthy hospitalization. At the same time, each discharge decision must be carefully made. As access to care is expanded, the staffing requirements of acute vs. continuing care are more demanding—especially for MD's and RN's, where recruitment is difficult because OMH salaries are not financially competitive. This continued transformation will require skill, time, patience, accountability, and support from State control agencies.

### **Transforming New York's approach to housing and residential care**

New York State has the nation's most extensive mental health housing program, with 39,000 units or housing opportunities, authorized through SFY 2007–2008, in place or under development. These programs, many developed through the *New York/New York* partnerships, have become national models for supportive housing and urban redevelopment. Yet the overall approach is inadequate as it is impressive. Erosion in the affordable housing marketplace means that housing needs are growing faster than OMH capacity. Shifting perceptions with respect to risk and liability (including intense media coverage of rare incidents of violence by people with mental illness) have led to a belief that all levels of care require heightened staffing and security. New York's success in developing an extensive "continuum of options" has a downside. Many staff and advocates have come to believe that consumers must move through many levels of care to independent living. This approach is inherently problematic: moving is especially stressful for people with psychiatric disabilities and can contribute to problems and re-hospitalization. Ironically, we know that admission to a hospital can precipitate homelessness. Oftentimes individuals can't pay their rent and utilities during a lengthy inpatient stay or are unable to move back with their families upon discharge.

OMH has launched a broad and multi-year approach to reform its approach to mental health housing. Working with our partners in the Administration, (Housing Finance Agency, Division of Housing and Community Renewal, and Office of Temporary and Disability Assistance)

housing production can be increased faster than by OMH working alone. This multi-agency approach is the genius of the Governor's proposed *Housing Opportunity Fund*. OMH is working with residential providers to emphasize a supportive housing model: providing safe, decent and affordable housing that is available long term, linked to flexible services that can be increased or decreased as needed. Making these changes is very challenging. Providers are concerned about resource levels and liability. Federal and State funding constraints reduce the flexibility of resources. However, we are gratified that the provider community has stepped up to offer innovative models, to identify challenges that must be addressed, and to participate in a collaborative approach to change.

## Balancing safety and quality with regulatory burden

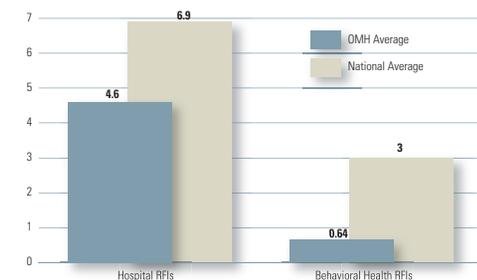
OMH is responsible for setting and enforcing standards for care in both public and private hospitals and community mental health programs. Over 2,500 mental health programs are regularly inspected. In addition, OMH must approve the entry of new providers. Maintaining a balance between safety, quality and the burden and cost of regulation is a constant challenge. I will say that during my own transition process, feedback about excessive regulation was far more intense than concerns that regulation was failing to protect the rights and safety of consumers. Finding the right balance is a basic responsibility of government.

To respond to these concerns, OMH has engaged with providers in a collaborative process to review standards, beginning with perhaps the most contentious area: how we review inpatient hospital services. OMH also worked closely with other State agencies to review standards for protecting children subject to restraint or seclusion while in care.

## Sustaining the quality of care in OMH facilities

The hospitals and community services operated by OMH are unique in state government in that they must meet both federal standards for quality but also the private standards for hospitals estab-

### Joint Commission survey results



Seventeen (17) of the Twenty Five (25) State Psychiatric Facilities were surveyed by the Joint Commission in 2007. The remaining facilities will be surveyed in 2008. All seventeen surveyed maintained Joint Commission accreditation. Survey outcomes are based on the number of citations which require a written plan of correction – called Requirements for Improvement (RFIs)

lished by The Joint Commission (TJC, formerly the Joint Commission on Accreditation of Healthcare Organizations). During 2007–2008, all OMH hospitals will receive unannounced 3–5 day TJC surveys. Nationally, 5–10% of all hospitals experience significant difficulties in the accreditation process, including denial of accreditation or conditional accreditation. To date, all surveyed OMH hospitals have received full accreditation. We expect the trend to continue, although we have concerns about outmoded facilities in several hospitals to be surveyed in 2008.

### Successful implementation of legislative initiatives.

The OMH has successfully met significant benchmarks for implementing new and complex legislative and judicial requirements during 2008. The most significant and complex of these are:

#### Child and Family Clinic Plus Implementation

- ◆ Over 100 clinics licensed to do Child and Family Clinic Plus.
- ◆ Child and Family Clinic Plus collaborations include:
  - ◆ 135 school districts (upstate and LI)
  - ◆ 191 schools in NYC
  - ◆ 53 early childhood centers in NYC
  - ◆ 38 preventative programs in NYC
  - ◆ 7 primary care practices (upstate and Long Island)
- ◆ Target number of screenings statewide is 246,000. Most will occur in schools (189,000).
- ◆ The program provides screening and evaluation and if necessary referral onto mental health services in the community.

#### Child and Family Clinic Plus and *Achieving the Promise*

This effort is the largest and most fundamental transformation of children’s mental health care underway in any state. Responding to the problem of late entry into care by children with emotional disorders, OMH designed the Child and Family Clinic Plus initiative, which was launched in the FY 2006 budget. This approach expands mental health clinics and places mental health professionals in collaborating sites (schools, child welfare agencies, early childhood programs, pediatric practices) where children (with parental consent) can be screened for problems and engaged in care. This approach, recommended in the 2003 Final Report of *The President’s New Freedom Commission on Mental Health* (chaired by now-OMH Commissioner Dr. Mike Hogan) will break the cycle of deteriorating health and late entry into care for children.

To implement this major change, a diverse array of children’s mental health agencies have entered into new partnerships with 296 schools, 38 preventative programs, 53 early childhood centers and 7 pediatric offices across New York. Other components of the *Achieving the Promise* effort include expansion of intensive/flexible home- and school-based services for children at risk of institutional placement, an innovative Evidence-Based Treatment Dissemination Center to train clinicians across the state in the latest, scientifically validated treatments, and a program to bring child psychiatrist consultation to our rural communities (telepsychiatry).

While implementation of Child and Family Clinic Plus is still underway, the budget proposes a very significant enhancement. Our early experience has been that including experienced Parent Advisors as core members of the Child and Family Clinic Plus program has improved its quality, efficiency and relevance. So the Governor's proposed budget with your support will expand this essential ingredient across New York State.

### Sex Offender Management and Treatment Act (SOMTA)

Faced with the prospect of dangerous sex offenders nearing release from prison, and court challenges to a hastily-constructed alternatives relying on existing mental health and corrections law, Governor Spitzer worked with you to enact the Sex Offender Management and Treatment Act early in 2007. The legislation created a unique "two track" approach to the civil commitment of dangerous offenders to either secure hospital care in specialized OMH facilities or "Strict and Intensive Supervision and Treatment (SIST)" under the authority of the Division of Parole.

Implementation of this legislation has been a major challenge for many participating agencies including the Attorney General, Department of Correctional Services (DOCS), Probation, Parole, and OMH. The challenges have perhaps been greatest for OMH, which has already reviewed over 1,000 cases of sentenced sex offenders to determine if they might be subject to civil management. Detailed psychiatric evaluations have resulted in over 135 cases where confinement or community supervision was potentially appropriate. Challenges to OMH include assisting at trial, transporting individuals to and from court hearings across NYS, developing facilities and protocols for treating offenders, and assisting Parole in developing community management and treatment plans. Further hampering our efforts have been limits in the State's system which have made hiring of qualified professionals (especially MD's and RN's) very difficult.

Nonetheless, and despite ongoing legal challenges, the OMH efforts have been remarkably successful and stand in stark contrast to efforts in other states whose sex offender programs are in disarray and are highly controversial because of implementation and quality problems.



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### Expanding and improving prison mental health care

- ◆ One 1 20 bed inpatient ward at Central New York Psychiatric Center: Spring 2008
- ◆ Five additional Intermediate Care Program (ICP) beds for a total expansion of 190 slots (at Albion, Bedford Hills, Fishkill, Great Meadow and Green Haven Correctional Facilities): expansion and new capacity should be operational by 12/08
- ◆ 215 Transition Intermediate Care Program slots (which is a step down from the Intermediate Care Program or ICP) located at various prisons where we operate ICPS: currently 75% operational, recruiting staff for remainder.
- ◆ 100 Bed Regional Mental Health Unit at Marcy Correctional Facility : projected completion 12/08
- ◆ 20 additional reception staff to screen all newly committed inmates to DOCS custody (operational 12/07)
- ◆ 24 additional Special Treatment Program slots to be located at Mid-State Correctional Facility: projected 8/08
- ◆ Four Special Housing Unit (SHU) Group therapy Modules for a total capacity to serve 48 inmates (currently operational at 3 sites – working on the 4th)
- ◆ Joint OMH/DOCS Central Office Review Committee to monitor status of SHU services at DOCS facilities (operational)

### Disability Advocates, Inc. (DAI) Private Settlement Agreement

With DOCS and the Attorney General, OMH negotiated a Private Settlement Agreement to resolve this long-standing litigation on care of mentally ill prison inmates. Implementation of the agreement, well underway, builds on the collaborative relationship between OMH and DOCS, and will improve the best and most extensive system of prison mental health care in any state. The agreement will require the OMH screening of every incoming DOCS inmate, greatly increase protections for mentally ill inmates, and expand prison mental health services at all levels: counseling/psychiatric care, special mental health residential units, dedicated intensive treatment programs, and OMH hospital beds at the Central New York Psychiatric Center.

### Completing and initiating required planning activities

For many years, OMH planning activities were carried out in a silo. Good collaboration with the County Mental Hygiene Directors was occurring, but the statutorily required *Statewide Comprehensive Plan* a.k.a., the “5.07 Plans” were not produced on time and were not well coordinated among the mental hygiene agencies. I am happy to report that we are back on track. The 5.07 plans were produced and submitted on time, with an increased level of coordination and coordination among the State agencies.

OMH has also launched a participative effort to develop a *Comprehensive Children’s Mental Health Plan*. We know that children with behavioral disorders enter care late and that their parents receive little timely advice, support and guidance. As a consequence, they experience failure in – and impose burdens on – schools and pediatricians. They are over-represented in the child welfare and juvenile justice systems; a problem that impacts disproportionately on children of color. The need for massive changes in our approach to children with behavioral disorders – which must involve earlier intervention, family-focused and family-driven solutions, and community-wide solutions – necessitates a clear plan and strong leadership by elected officials.

## New approaches to Interagency Collaboration: Managing with “lateral vision”

OMH is engaged in new, intense partnerships with many sister agencies. In some cases (e.g. the OMH/DOCS partnership) mutual collaborations had begun prior to this Administration. However, in several cases, necessary working relationships had eroded or were non-existent. The failure to collaborate or even communicate was a core concern articulated by consumers, families and professionals during the *People First Listening Forums* conducted by the health commissioners during the Spring and Summer of 2007.

Several of the most intense and productive new partnerships that are underway between state agencies include:

- ◆ *Renewed activity and collaboration of the Inter Office Coordinating Council (IOCC).* With the shared leadership of Commissioners Karen Carpenter-Palumbo and Diana Jones Ritter, the IOCC has convened (for the first time in over 15 years) and submitted its first joint report in recent memory. A webcast of the last IOCC meeting (January 18, 2008) is available through all three agencies’ home pages. The IOCC will focus on addressing and resolving inter-agency issues and concerns, and continuing and enhancing a shared approach to planning.
- ◆ *Collaborations between OMH and OMRDD, OMH and OASAS, and OMH and DOH* to improve services to individuals with the respective “dual diagnoses.” In the case of individuals with both a developmental disability and mental illness, the numbers affected are relatively small, but the impact on consumers, families and caregivers can be catastrophic. Problems in accessing care for this relatively small but high-need population were spoken strongly in all of the commissioner’s forums. OMRDD Commissioner Jones Ritter and I have worked with our senior staff to articulate a simple new philosophy of collaboration. The preference is for services and solutions that will support people in their communities rather than in institutions. And the assumption is that



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## Housing Opportunity Fund

“In too many parts of our state, our children cannot afford to come back to the neighborhoods that they grew up in, and their parents cannot afford to stay in the homes where they raised their families... I will propose the biggest housing initiative in a generation, a \$400 million *Housing Opportunity Fund*.”

Governor Eliot Spitzer  
January 9, 2008



in most cases both service systems will have something to offer, rather than an old approach of denying access until one agency “caves.” We have conducted a statewide videoconference among the leadership staff in both agencies, and collaborated with County directors.

In the case of people with co-occurring mental illness and alcohol/drug problems, Commissioner Carpenter–Palumbo and I convened a task force to recommend improvements, accepted the recommendations of the group, appointed action teams to develop and implement specific recommendations (in the areas of: clinical practices, regulatory barriers, and financing) and are jointly meeting with staff every six weeks to monitor and support progress. Given that one third to one half of individuals with mental illness or addiction experience both disorders, this collaboration is hailed by advocates who foresee access to better integrated care.

We are very appreciative that the Governor has proposed the resources we need to reinforce and accelerate the development of integrated services.

Efforts between OMH and DOH/Medicaid to improve access to clinic care were described earlier. We need to improve access to health care for mental health consumers, and to mental health care for people who rely on health clinics. In addition, OMH and DOH staff are focusing together on consistent approaches to regulation that minimize burden while protecting patients.

### **Collaborations to address housing needs**

In response to the overwhelming challenges faced by individuals with mental illness to find affordable housing, the new collaborations among OMH, HFA, OTDA and DHCR are essential. These collaborations include pooled financing of projects, increased collaboration, and elevating the priority of special needs supportive housing. The collaborations will yield dozens of housing projects and hundreds of units of housing within the next few years in addition to the breakthrough development that will occur via the Governor’s proposed *Housing Opportunity Fund*.

## Collaboration on “cross-system” youth

Despite available vehicles for coordination of services for children (e.g. the Council on Children and Families), there has-until recently-been limited Commissioner-level collaboration on the multi-system issues and challenges facing many New York children and families. To begin to address these problems, Commissioners of many child-serving agencies in the Governor’s Cabinet-with the additional interest and participation of Commissioner Mills of the Department of Education/Board of Regents-have met to revive an agenda for collaboration. This retreat – including conversations with parents and youth experiencing services and problems in many systems – has led to a commitment to ongoing work together to meet the needs of these children.

## The challenges that lie ahead

**W**HILE POLICY CHALLENGES ARE INVIGORATING, the first challenge in any large and complex agency is to maintain and improve the services and programs that are already in place. In OMH, where responsibilities are diverse and range from operating hospitals to funding and regulating care provided by over 2,500 agencies through 57 local governmental units including New York City, the task of day-to-day management is as complex as any in state government. This is particularly true given the complex nature of operating systems in New York.

Our second, essential priority is to carry forward the transformation that has begun in New York’s mental health system. “Transformation” of government is a theme of the Spitzer Administration. In the mental health world, “transforming” care was the call of the President’s New Freedom Commission on Mental Health. To achieve this, as my testimony illustrates, changes have been launched in OMH hospitals, housing and residential care, outpatient services, regulatory operations, multiple inter-agency efforts, children’s services, and relationships with law enforcement and corrections agencies.

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Our approach to “transformation” is not to emphasize top-down or bureaucratic change. Rather, we seek changes that may be subtle but fundamentally shift important priorities and processes. This means that we are working on many fronts at once. Sustaining these efforts (in addition to program and legislative initiatives) is a major task.

Looking forward, we see areas where the problems are too deep and systemic for immediate resolution (such as a fragmented system, unemployment among people with mental illness, massive needs for care for children). In these areas, we will seek steps toward more comprehensive solutions and work with our sister agencies, providers, consumers and the general public to achieve mutual goals.

At a deeper level, the theme of transformation (change that is not bluntly imposed from on high, but “to change the nature, function, or condition” of something) is consistent with our emerging understanding of mental illness and mental health. New science reveals how the brain can be modified by experiences (e.g. by trauma, or via successful therapy). At the same time, the mental health field—taught by service recipients and researchers—is learning that people are actors in their own recovery, not passive recipients of treatments. Drawing from this, a third major leadership challenge in New York’s mental health system is to communicate realistic hope—itsself the engine of change—to people and organizations at every level.

As I noted at the beginning of this testimony, the 2008–09 Executive Budget Request builds upon the work we have done and recognizes the unique challenges we face to assure quality accessible mental health services in New York State.

### **Addressing the inequities in mental health care clinic financing**

Governor Spitzer’s health care reform initiatives for this budget, seek to increase access to quality and ambulatory care while reducing the reliance on more costly inpatient and emergency care. To achieve the Governor’s priorities for mental health, the Office of Mental Health, in

partnership with the Department of Health, propose restructuring Medicaid reimbursement for mental health services. Any effort to improve access and decrease fragmentation and reliance on costly inpatient and emergency care needs to recognize barriers to access and the inherent funding inequities which have defeated substantial change in the system.

The Executive Budget request proposes new funding to implement the first steps in a multi-year plan to improve access and eliminate the inequities that have long plagued mental health clinic care. This budget takes first steps in improving access and making financing more equitable while we work with stakeholders to develop permanent funding mechanisms that will eliminate barriers to services, reduce over-reliance on inpatient care and improve consistency in financing among providers.

The proposal would:

- ◆ *Establish minimum reimbursement rates* for clinics licensed solely under the Mental Hygiene Law, adjusted regionally;
- ◆ *Eliminate future Comprehensive Outpatient Programs (COPS) volume rebasing* and the reconciliation to the COPS threshold;
- ◆ *Remove the so called Medicaid neutrality cap*, and;
- ◆ *Limit COPS-only payments to services* for which a Medicaid managed care plan has provided or approved payment.

We are confident that these proposed changes along with Article VII bill language to address the rebasing of inpatient psychiatric Medicaid rates will achieve the goals set forth by Governor Spitzer to improve access and decrease fragmentation.



Governor Spitzer's health care reform initiatives for this budget seek to increase access to quality and ambulatory care while reducing the reliance on more costly inpatient and emergency care.



<b>Priority</b>	<b>Initiative</b>	<b>Budget Increase</b>
Addressing inequities in mental health clinic financing	1 Establish minimum reimbursement rates for clinics licensed solely by OMH	\$4.8 million in State share Medicaid for all initiatives (\$9.8 million gross Medicaid)
	2 Eliminate COPs volume rebasing and reconciliation to the COPs threshold	Proposal annualizes to \$9.7 million (s/s) or \$19.4 million gross Medicaid
	3 Remove the so called Medicaid Neutrality Cap	
	4 Limit COPs-only payments to services for which managed care has provided or approved payment	

This Budget Recommendation also includes \$800,000 in new funding to expand access to vocational services within the Personalized Recovery Oriented Services (PROS) program.

### **Improving access while decreasing fragmentation in the children’s community mental health system**

Through a number of initiatives, such as the State Children’s Health Insurance Program (SCHIP) and the Children’s Cabinet, the Governor has made a commitment to the health and well being of New York State’s children. The Office of Mental Health took up this challenge in its *Achieving the Promise* plan to develop and implement integrated outreach programs, screening and treatment protocols and access to services. The Executive Budget Request supports this work by:

- ◆ *Adding Family Support Services* to those already covered under the Child and Family Clinic Plus program;
- ◆ *Removing barriers* to specialty mental health services for children by allowing for the

designation of more clinics that serve seriously emotionally disturbed children through a fee for service mechanism, and;

- ◆ *Expanding the Children’s Rural Telepsychiatry initiative* by adding 10 more counties where child psychiatrists may not be available.

<b>Priority</b>	<b>Initiative</b>	<b>Budget Increase</b>
Improving access while decreasing fragmentation in the children’s community mental health system	1 Adding Family Support Services to Child and Family Clinic Plus	\$1 million Annualizes to \$5 million
	2 Removing barriers to specialty mental health services for children	\$200,000 Annualizes to \$300,000
	3 Expand the Children’s Rural Telepsychiatry initiative	\$300,000

Further, the Budget Request continues funding for implementing the initiatives under *Achieving the Promise*. These include the Child and Family Clinic Plus program, Home and Community Based (HCBs) Waiver slots, the Evidence Based Treatment Dissemination Center and the Rural Telepsychiatry program.

### **Improving access and decreasing fragmentation for high need and high cost populations**

Within any population there are individuals who use a proportionately higher level of services because they have more than one illness or disability occurring at the same time. These high need and high cost individuals require services that are tailored to address the person as a

whole. Research has shown that by addressing the co-occurring needs of these individuals provides better outcomes and reduces the costs associated with their care.

The Executive Budget Request supports the goal of treating high need/high cost individuals by:

- ◆ *Providing new funding for OASAS/OMH demonstration programs* to address the treatment needs of persons with co-occurring psychiatric disabilities and addictions;
- ◆ *Providing support for OMH to implement two demonstration programs* of effective integration of health and mental health services, one to be located in Western New York and one in New York City;
- ◆ *Augmenting services for prison inmates with mental illness* consistent with statutory changes.

<b>Priority</b>	<b>Initiative</b>	<b>Budget Increase</b>
Improving access and decreasing fragmentation for high need and high cost populations	1 Demonstration programs for co-occurring disorders	\$1 million Annualizes to \$2.5 million
	2 Integrated health and mental health demonstration programs in Western New York and New York City	\$1.5 million Annualizes to \$2 million
	3 Enhancing mental health services for incarcerated individuals	\$8.5 million

The Governor’s proposal also annualizes funding to continue the Geriatric Mental Health Services Initiative as well as funding for OMH/DOCS enhancement of mental health services to prison inmates with a mental illness.

## Improving access to housing

The Governor's Budget Recommendation recognizes that individuals with mental illness need stable housing in the community. This Budget includes the creation of additional housing opportunities which, when completed, will result in nearly 41,000 community housing opportunities (including NY/NY III units). Further, Article VII language is proposed which will allow for the development of integrated housing in community settings.

New Funding will allow for:

- ◆ *Expanding Supported Housing opportunities* by 1,500;
- ◆ *Providing capital funds* to develop 500 integrated Single Room Occupancy (SRO) units of housing;
- ◆ *Providing capital to purchase adult homes* that have closed or will be closing for conversion to OMH housing in partnership with DOH and the Commission on Quality of Care and Advocacy for Persons with Disabilities.

Continued development of prior year commitments (1,000 Supported Housing opportunities and 1,000 congregate care units originally funded in 2007/2008) is also supported in this budget.

Priority	Initiative	Budget Increase
Improving access to housing	1 1,500 Supported Housing opportunities	\$1.1 million Annualizes to \$18.1 million*
	2 500 SRO units	\$125 million (Capital)
	3 Capital to purchase adult homes	\$20 million (Capital)
		* Over 5 years

## Quality Workforce

The bedrock of the mental health system is in its staff. Quality in service can only be achieved by recruiting, retaining and maintaining a workforce sufficient in knowledge and experience to deliver these services. The Budget proposal recognizes this key fact and provides:

- ◆ *For the implementation of the final year of the current three year COLA* for certain locally operated mental health programs;
- ◆ *The extension of the COLA commitment* for another three years through 2011/2012;
- ◆ *For the implementation of the second year of a three year commitment* to increase funding to Community Residence (CR) and Family-Based Treatment programs (FBT);
- ◆ *Enhanced reimbursement to Family Care providers*, and;
- ◆ *Targeted salary enhancements to the State workforce* to allow for more competitive recruitment for certain clinical positions.

Priority	Initiative	Budget Increase
Quality workforce	1 Implement year three of the COLA	\$30.1 million
	2 Extend COLA to 2011/2012	Article VII legislation
	3 Funding to CR and FBT programs	\$12 million
	4 Family Care	\$1.5 million Annualizes to \$3 million
	5 Clinical State workforce	\$2 million Annualizes to \$12 million*
		* Over 3 years

## Promoting public mental health

Outreach and education about mental health are important ingredients to provide the public with the knowledge they need to maintain good mental health. The Governor's Budget request supports these activities by:

- ◆ *Providing new funding* to support the implementation of the New York State Workplace Violence Prevention Law, and;
- ◆ *Continuing funding* for efforts to implement the NYS Suicide Prevention Plan.

Priority	Initiative	Budget Increase
Promoting public mental health initiatives	1 Workforce Violence Prevention 2 Continue Suicide Prevention funding of \$1.5 million	\$520,000

## Research

The Executive Budget Request acknowledges that research is essential for the identification of the causes of mental illnesses and the development of interventions that are proven effective to treat them. Annualized funding is provided for:

- ◆ *Continued support for 25 research scientists* authorized in 2007/2008 at the New York State Psychiatric Institute and the Nathan Kline Institute (\$2.4 million), and;
- ◆ *Continued funding for the Cultural Centers of Excellence* to promote the development of best practices in delivery of culturally and linguistically competent mental health services (\$2 million).

Priority	Initiative	Budget Increase
Research	<ol style="list-style-type: none"><li>1 Continuation of 25 research scientists totaling \$2.4 million</li><li>2 Continuation of funding for the Centers of Excellence for the promotion of cultural competence totaling \$2 million</li></ol>	