



New York State
Office of Mental Health

**2009–2010
Mental Health Update and
Executive Budget Testimony**

January 29, 2009

New York State
David A. Paterson, Governor

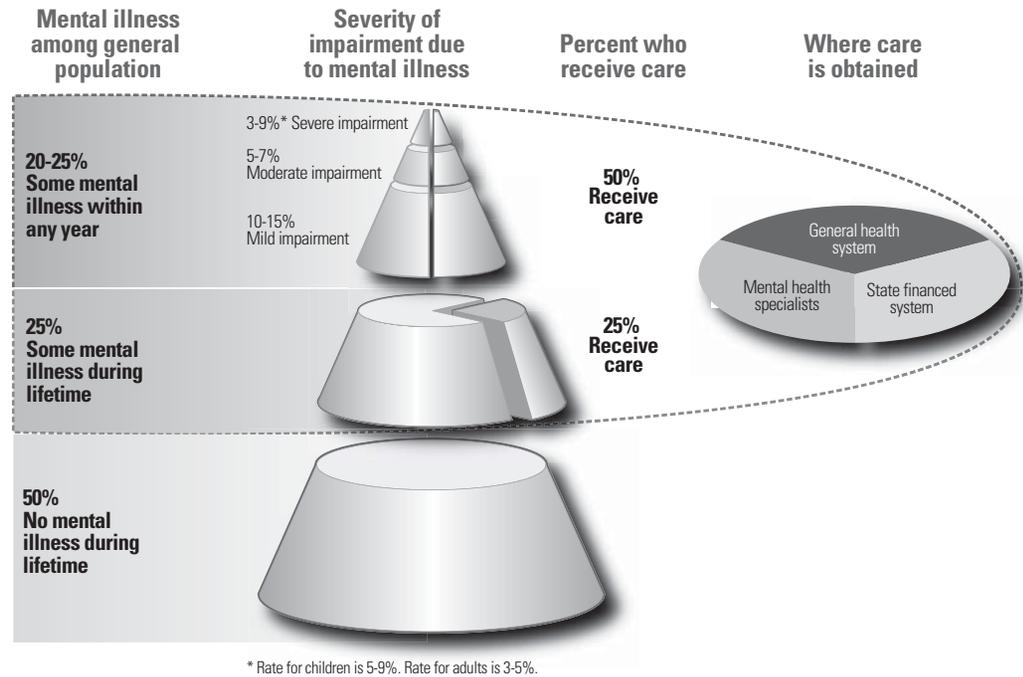
Office of Mental Health
Michael F. Hogan, PhD
Commissioner

Governor Paterson’s recommended budget for the Office of Mental Health for 2009-2010 is a good, tough proposal. You will want to hear about the implications of both cuts and spending. However, it is essential to set the stage by reviewing the impact and significance of mental illness, as well as the status of mental health care in New York and our efforts to improve it. We must also be aware of the scope and urgency of the economic challenges we face, and the possibilities that are raised by the presence of a new Administration in Washington that is attuned to the need for health care reform. The proposed OMH budget reflects and responds to all of these challenges and opportunities.

The scope and significance of mental illness often escapes us individually unless we or someone close to us is touched by it; both mental illness and mental health care lie behind a veil of stigma. Similarly, despite the enormous cost and impact of our mental health system, it is generally not a high public priority, except at those times when crises or incidents demand our attention. When this occurs, for example with public awareness of the behavioral health impact of war and how hard it is for our military families to get care, we have an unpleasant example of what people with mental illness and their families confront daily.

Mental health problems are prevalent and troubling, with one in ten New Yorkers affected by mental illness that is serious enough to affect functioning every year. Gaining access to good care is like running the steeplechase; there are many obstacles (recognizing the problem when its very symptoms can

Patterns of mental illness and mental health care



impair judgment, getting past the shame and stigma to seek help, dealing with insurance limits and obstacles, finding the right provider, and sticking with treatment when the response may be slow, incomplete, and uncomfortable).

Because of these obstacles, we now understand that although the average age at which mental health problems first appear is 14, the average delay in entering care is nine years. This is a long time to live with problems that can get worse without the right

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care, and adolescence and early adulthood are the worst time for them to emerge. These dynamics contribute to mental health concerns being a leading reason for school failure, the leading cause of adult disability, and the third leading cause of death (via suicide) of young adults. Additionally, we are aware of the pervasive impact of offenders with mental illness at every level of the criminal justice system, and the fact that individuals with mental illness are grossly over-represented among the chronically homeless. When it comes to mental health, the phrase “you can pay me now, or you can pay me later” is all too true.

Given the substantial and tragic impact of mental illness, where the cost in lost wages alone is about \$200B annually in the United States, we would do well to understand what excellent care looks like, and how we are doing in New York and the United States to provide it. Many of the dimensions of good care are as well known as the failure to provide it is stark. These challenges are at the heart of our efforts to improve mental health care in New York, and are reflected in this proposed budget.

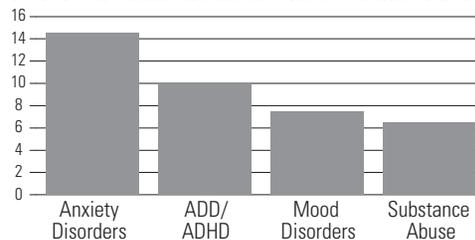
vide them with immediate support—and perhaps even more importantly, we would provide their parents with “Super Nanny” style education and assistance. Instead, a study by the Yale Child Study Center estimates that more young children are expelled from preschool settings for misbehaving than from all the public schools. This is but one example of the challenges in providing early access; I will discuss our initial recommendations (emerging from our path-breaking Children’s (Mental Health) Plan) later in my testimony.

Good care is personalized, continuous, and integrated

We now know that, to quote former First Lady Rosalyn Carter, “recovery is possible for anyone with a mental illness.” Therefore, the mental health field rejects the idea that mental illnesses are “chronic” with its implication that things will inevitably get worse and that there is not much an individual can do about it. On the other hand, the evidence does confirm that most mental health problems are long-term and episodic. Like other illnesses (e.g., diabetes, multiple sclerosis) there may be times when a person seems in very good health and other times when the illness “takes over.” Learning to manage the symptoms and adjust one’s life to cope with the illness is the essence of recovery. And the single most important aid to recovery—after one’s own awareness—is a continuous relationship with a trusted health professional.

The structure of American health care, our bias in New York toward inpatient and “episodic” acute care,

Median duration in years of delay before treatment after onset of disorder



Early access to care

The delay in identifying problems and entering care is an obvious example; a nine year delay would be flat out unacceptable for any other health condition, even ones that are far less serious. But the challenges in solving this problem are immense. To do better, for example, we would identify children with emerging behavioral problems in early education, and pro-

and the sheer size and complexity of New York’s mental health “system” militate against continuous healing relationships. In many cases care may start in a general medical setting (e.g., a pediatric or medical clinic) but then move to a separate mental health program. Hospitalization when the illness is out of control is perfectly appropriate but may disrupt a living situation, and result in discharge to a different provider. The Depression and Bipolar Support Alliance (a well respected national self-help, peer support and advocacy organization) has found that it takes people on average over 10 years to find the right “cocktail” of medications to manage bipolar disorder with reduced symptoms and acceptable side effects. Discontinuous care is not a good recipe for developing a good rapport with a health professional and for learning self-management. We have major work to do to reduce barriers to continuous care that engages people in finding solutions in their own life.

Emphasis on “living, learning, working and participating fully” in one’s community

The episodic and long-term nature of most mental illness means that learning how to live one’s best life with the illness is the essence of recovery. The best treatments that are available (e.g., medications, appropriate psychotherapy) do not cure the illness, but rather help with it’s symptoms. Thus, the best care helps people figure out how to live their lives, building on strengths and working around symptoms. As mental health care has been increasingly financed on a health insurance model, attention to treating symptoms has often driven out approaches that do



not seem “medically necessary” even if in the long run they are more effective. Thus, while success in school is urgently important for children, mental health treatment focuses on symptoms rather than school success. Meanwhile, the disconnect between educators and treatment contributes to the sad fact that children receiving special education “emotional disturbance” services have the worst educational outcomes among all students with disabilities. Similarly, while holding down a job is critical to adult success, employment services are not covered by Medicaid, while people with a mental illness have the worst outcomes in vocational rehabilitation services. An insurance driven model also cannot comfortably reimburse for self help and peer support, although these approaches are preferred solutions for many individuals, with known effectiveness.

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The central implication in this budget is our effort to preserve capacity in existing safety net programs while simultaneously restructuring for efficiency.

Later in my testimony, I will discuss our approaches to addressing these long-standing problems. They represent the core challenges we must confront, and budget limits must not be deter us from trying to solve these systemic challenges that result in wasted dollars and lost lives.

The core mission of OMH

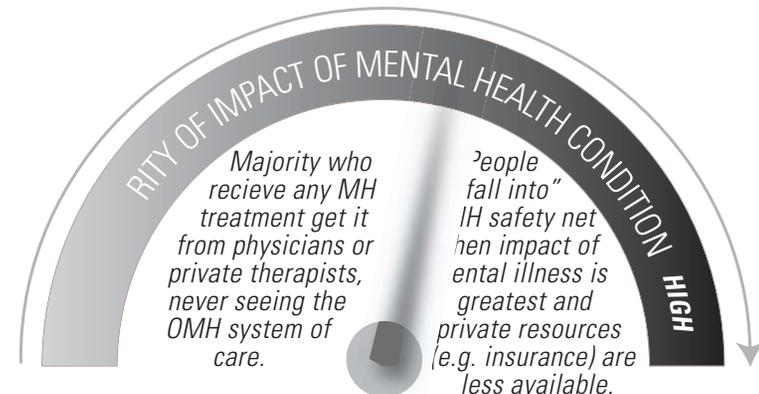
As we seek to address these fundamental problems, we are grounded in our statutory mission, which defines the “safety net” role of OMH and the services we provide and oversee. In general, these services are properly oriented toward adults with serious and persistent mental illness, and children and youth with serious emotional disturbance. For the majority of people who receive any mental health treatment, it starts and ends without ever seeing an OMH operated, funded, or regulated program. Instead, they receive a prescription from a pediatrician or other physician, or perhaps see a private therapist. While there are limits to the quality of care that a non-specialist can provide—especially for more serious conditions—care in the general medical sec-

tor is the norm for people who get any mental health care at all.

When things get more serious, and especially when the impact of mental illness is so severe that it impacts functioning (family, school, work), people tend to “fall into” the OMH safety net of programs operated by hospitals, counties, non-profits and OMH itself. This division of labor is both appropriate (the state should be oriented to those most in need) and also inherently problematic (moving between levels of care is inconvenient at best and seriously disruptive at worst).

This illustrates how the overall health care system is both a preferred and problematic location for mental

OMH safety net provides care for those most affected by mental illnesses



health care, and why national health care reform must include and address problems in mental health care as a central issue. Care in the general medical sector is often preferred by patients (it is more convenient and less stigmatizing) but it often fails. Problems include insurance and expertise limits and the adequacy of reimbursement for mental health care within primary care (e.g., the extra time needed for the thorough history needed for a pediatrician to make an accurate diagnosis of ADHD, and then for the time needed to coach parents in how to best parent a child with attention problems-not just to prescribe medication).

These challenges illustrate how OMH must work to preserve core “safety net” functions for those most in need, while simultaneously working to improve care “upstream” (as illustrated in the Children’s Plan). The central implication in this budget is our effort to preserve safety net programs while simultaneously restructuring for efficiency.

The crucial and challenging role of Medicaid

Nationally and in New York, Medicaid has become the largest payer for mental health care. Medicaid pays for mental health care in multiple ways: As the dominant funder of care for OMH provided and regulated services, as the primary payer of specialty mental health services within the Department of Health overall Medicaid program (e.g., inpatient and general hospital outpatient psychiatric care) and for people with a mental illness within the overall health

care system (e.g., medications) and long term care system (e.g., nursing homes, home care).

Medicaid’s role has brought huge benefits and huge challenges to New York’s mental health system. On the one hand, federal participation has allowed expansion of care far beyond what the state could provide otherwise. On the other hand, Medicaid’s benefit for mental health care is subject to arbitrary federal policy (e.g., Home and Community Based Services waivers like the successful NYS CARES program for individuals with a developmental disability are not available for adults with a mental illness). Additionally and as described above, Medicaid’s health insurance focus has made it very challenging to provide supportive and rehabilitative services. Additionally, the Bush Administration’s leadership of Medicaid has been problematic, with dilatory review of proposals for change that has impeded some of New York’s efforts to bring about improvements in care. Finally, the complexity of Medicaid itself has interacted with the complex and dispersed nature of New York’s mental health system to greatly increase fragmentation of care, and make accountability more complex.

For all of these reasons, there can be no fundamental improvement in mental health care in New York without extraordinary collaboration between OMH and DOH/Medicaid. Similarly, DOH goals for health care reform cannot be fully achieved without collaboration and attention to mental health issues in Medicaid. OMH has been working intensively with DOH on a mutual reform agenda to begin to address these challenges, and many aspects of this joint re-

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form agenda are reflected in this budget. These challenges include:

- ◆ Irrational, inconsistent, unsustainable, and inefficient reimbursement for outpatient clinic care.
- ◆ Overutilization of inpatient care is driving access problems. Fiscal stressors are contributing to closure of general hospital psychiatric units. There are excessive demands on emergency rooms.
- ◆ Coordination of care (among mental health providers, between medical and mental health providers, and especially for individuals with multiple needs) requires additional improvement.
- ◆ NYS has historically emphasized setting-specific treatment services, and does not achieve adequate levels of rehabilitation, less expensive self-help and peer support, involvement of families, care coordination and care management.

**A demanding reform agenda,
 especially for a challenging budget**

This is a difficult and important time for New York’s mental health system; almost everything is under reform simultaneously, while day-to-day work remains challenging and the external environment is getting more difficult. Reducing the growth of spending is imperative; doing it in a way that does not cause reform to stall is just as urgent. Major and cross-cutting reform efforts now underway include:

Increasing the productivity and focus of OMH hospitals

OMH’s Psychiatric Centers (hospitals) are the ultimate “safety net within the safety net,” providing the most intensive care for the individuals with the most intractable mental illness. All categories of hospitals (child, adult, forensic) provide both inpatient treatment and community care programs (in the case of the forensic hospitals, “community care” is provided within Department of Correctional Services-DOCS) prisons. The bulk of OMH State Operations resources and services are devoted to adult services, with 4,000 current hospital beds and over 20,000 individuals cared for in community programs.

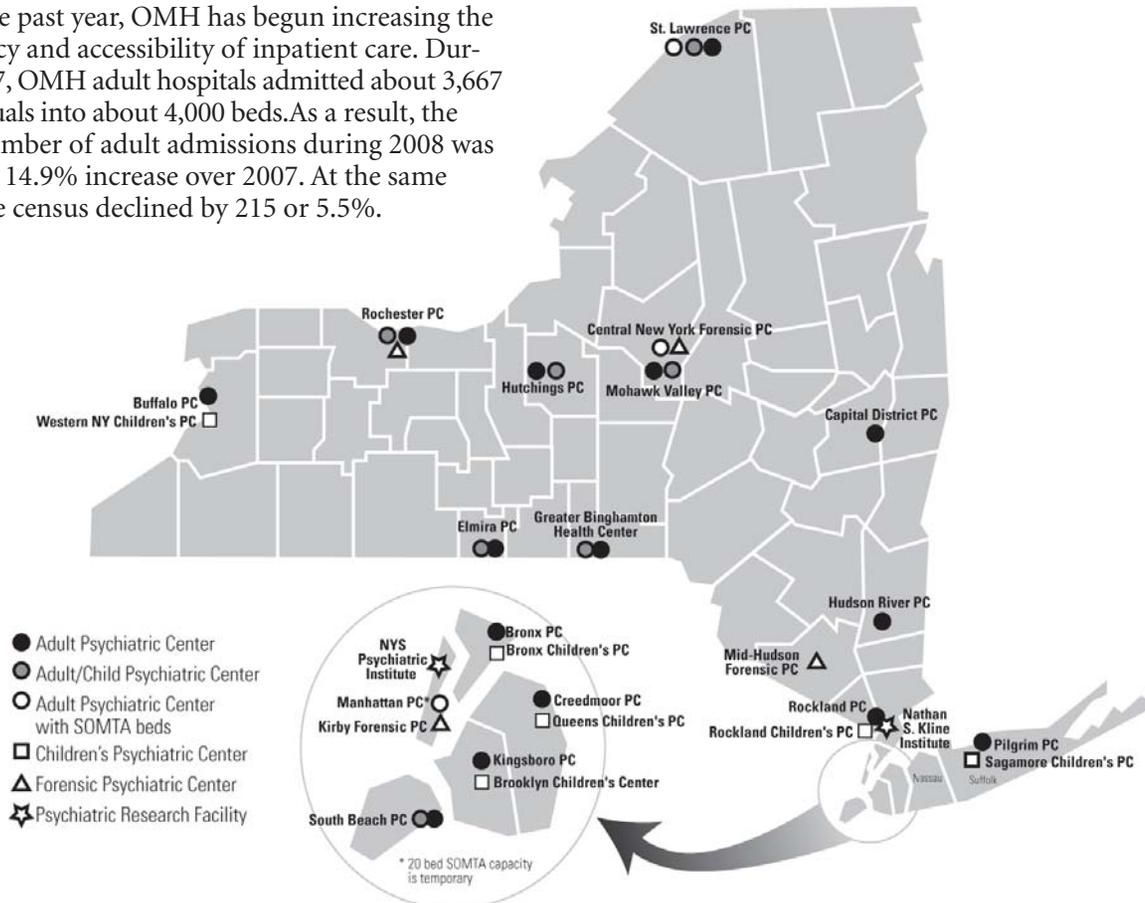
Historically, the adult hospitals evolved from the asylums of the 19th and early 20th century to full service facilities. Within the last 20 years, driven in part by the availability of Medicaid reimbursement for short-term psychiatric treatment (mostly in general hospital units), New York—like some other states—sought to meet the need for brief hospital care in general hospital units while carving out a “back-up” intermediate or long term role for the adult hospitals. This arrangement in some ways has served the state reasonably well. Many OMH hospital beds continue to be occupied by individuals who remain there due to lack of housing, intensive community services, or simply by reputation—despite OMH’s best efforts. Ironically, the longer one stays in a hospital, the harder it can be to leave, as skills of community living are eroded by the routines of institutional life. As a result, these intensive services are often inaccessible, leading some to observe that

“it’s easier and quicker to get into Harvard than a state hospital.”

Increasing the efficiency and accessibility of inpatient care

Over the past year, OMH has begun increasing the efficiency and accessibility of inpatient care. During 2007, OMH adult hospitals admitted about 3,667 individuals into about 4,000 beds. As a result, the total number of adult admissions during 2008 was 4,212, a 14.9% increase over 2007. At the same time the census declined by 215 or 5.5%.

We are now extending this focus to ensure that hospital-operated community services are delivering maximum value, and complimenting community services provided by non-profits and general hospitals. Examples of these high-impact community services include children’s day treatment/school



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programs that provide an alternative or a bridge to successful community life for hospitalized youth; on-grounds residential programs that care for individuals with multiple needs; and intensive mobile treatment teams that work with high need individuals. During 2009, improving the focus and efficiency of both inpatient and community services will be a focus of local services planning with the County Mental Hygiene Directors.

Medicaid mental health reform

The most complex, and perhaps the most urgent strand of reform for OMH, concerns Medicaid financing. Reform must be planned and coordinated carefully with DOH/Medicaid, recognizing the parallel challenges and agendas of mental health and health reform. Reform during a very challenging budget environment is doubly difficult; the conventional wisdom has been that change must be paid for with more money.

Medicaid mental health reform was launched successfully last year, with changes in the financing, regulation and emphases of clinic mental health care. Consistent with overall health care reform, these changes were designed to increase access to ambulatory care, ultimately reducing the need for hospital care. Changes in the past year reduced and removed regulatory barriers to clinic expansion and began to attenuate the corrosive effects of the complex “COPS” supplemental rate strategy-developed years ago as an alternative to general fund budget cuts.

These initial reform steps position OMH and its providers to begin movement into a second, multi-year phase of reform. The focus of this approach is to move toward a consistent and more uniform reimbursement strategy that allows the system to become compliant with the financing requirements of HIPAA-the Health Insurance Portability and Accountability Act. HIPAA requires health payers to pay for discreet services, rather than the current OMH approach that involves the same payment approach for a doctor’s visit as one to a therapist, and for a complex evaluation session as for a routine visit. OMH has been working with all stakeholders over the past year to design the parameters of this approach-the same methodology (termed Ambulatory Patient Groups or “APG’s”) that is being phased in this year for general health providers in Medicaid. The highlights of the plan are: gradual implementation beginning late in 2009-2010, a four year phase-in to assist providers in adapting, consistent rate structures that differentiate (e.g., among downstate and upstate providers), and payment rates that are linked to the complexity of the service being delivered.

While reforming reimbursement for Medicaid outpatient services, DOH is also collaborating with OMH to create a reimbursement pool for uncompensated care (medically necessary mental health treatment for individuals who are not Medicaid eligible) to improve the adequacy of and consistency in reimbursement of mental health services to individuals enrolled in managed care plans, and to manage the transition to this new system.

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A second challenging problem at the interface of DOH and OMH responsibilities relates to psychiatric inpatient care. As described above, most short-term hospital treatment of acute mental illness is now provided in general hospital psychiatric units, not in state hospitals. Medicaid is the largest payer of this care. And there are many problems. Despite high numbers of beds and high expenditures compared to other jurisdictions, access to acute psychiatric inpatient care is frequently hard to achieve, because patients stay longer on average in NYS units than they do in most other states. Problems in finding housing—a necessity for stable adjustment post discharge—is a leading cause of long stays. Access problems mean that many psychiatric patients are stuck in crowded emergency rooms. Hospitals that have specialized psychiatric emergency rooms (Comprehensive Psychiatric Emergency Programs or CPEPs) are often overcrowded as well. Emergency departments without separate psychiatric facilities are often disturbing environments for people in a psychiatric crisis, and their presence can greatly complicate delivery of other emergency medical care. Finally, for patients who are treated in and discharged from Medicaid-paid inpatient psychiatric care, the readmission rate within 30 days in NYS is much higher than national norms, suggesting problems in connecting these individuals to needed follow-up care.

Fiscal problems are also prominent. The payment system for Medicaid inpatient psychiatric care remains antiquated, flawed, and arbitrary. This contributes to a pattern of hospitals closing psychiatric units, a recurrent theme across NYS. Psychiatric care is reimbursed at lower rates than other medical specialties, and a

higher proportion of patients are uninsured. Medicare still retains arbitrary limits on psychiatric inpatient care. All these factors contribute to financial instability of psychiatric units, and resulting closures that deprive communities of urgently needed care.

OMH and DOH are advancing a multi-path strategy to begin to address these problems. OMH is intimately involved in these reform efforts reflected in the DOH budget. *A first proposal is to overhaul reimbursement for acute inpatient psychiatric care in Medicaid.* Reform should make reimbursement more adequate and equitable; it should favor highly accessible care over inefficient, long stay care. A modernized approach to reimbursement of acute psychiatric care in Medicare—developed with significant input from New York hospitals—offers an attractive alternative. *Second, OMH and DOH will work to develop alternatives to costly and ineffective repeat emergency room use.* As in other areas of acute medical care, a small percentage of individuals use a high volume of emergency room and acute inpatient treatment (psychiatric, medical, alcohol and drug treatment) because their ongoing treatment is not adequate. We will address, and evaluate the benefit of, alternative care for these individuals who will be identified by emergency department staff and through examination of patterns of expensive and repeat care.

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viduals who have multiple long term or “chronic” illnesses. People with serious mental illness are over-represented in this group for several reasons: Their physical health is often greatly compromised (due to high rates of smoking, poor diet and exercise, indifferent medical care and tragically, the side effects of psychiatric medication treatment). For these reasons, approaches to *integrate, coordinate and monitor the overall care of people with serious mental illness are urgent*, and we are addressing them on multiple fronts. These include:

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- ◆ *Coordination of care pilot projects*—The OMH Budget proposal continues funding for two managed care pilot programs. These programs will seek to improve outcomes for individuals with mental illness who are also part of Medicaid Managed Care programs. Additionally, the DOH recently announced regional demonstration projects to address complex health care needs and social barriers to care for chronically ill Medicaid beneficiaries. Some of the organizations selected for participation in these demonstration projects serve individuals with serious mental illness.
- ◆ *PSYCKES (Psychiatric Clinical Knowledge Exchange System)*—is a path-breaking initiative that supports both clinical decision making and quality improvement. PSYCKES provides prescribers and treating clinicians with access to Medicaid data for their patients and expert medical guidance on two major prescribing challenges in treating adults and children: Reducing questionable “polypharmacy” (the use of multi-

ple medicines) and decreasing cardiometabolic risk. PSYCKES is now being implemented in over 345 clinics in New York State. During 2009-2010, PSYCKES will expand to address additional quality concerns, and access will be provided to additional treatment settings and to consumers as well. Individuals with mental health problems die an estimated 25 years earlier than other individuals without mental illness. Much of this is attributable to health risks such as diabetes, obesity, high blood pressure and smoking. By using PSYCKES, physicians caring for these individuals will be able to better manage prescription treatments while remaining vigilant about the additional health risks posed by some medications.

- ◆ *Intensive Care Monitoring*—During 2008, OMH participated in the NYS-NYC Mental Health/Criminal Justice Review Panel, appointed by the Governor and Mayor Bloomberg to review incidents of violence and criminal justice problems involving people with a mental illness. A key recommendation of the Panel was development of a database to track and follow-up on patterns of problematic care (e.g., gaps in care, frequent emergency room visits) for people with substantial histories of mental health care who should be receiving intensive care. The recommendation followed from a finding that some such individuals were involved in incidents after lapses in care. The first phase of this initiative will be put in place during 2009-10, and provides another vehicle for monitoring care of people who need it, and may be at risk without better engagement in services.

- ◆ *Improving care coordination for people with mental illness enrolled in HMOs.* —DOH and OMH are working together to improve the adequacy and coordination of care for people enrolled in HMOs and also receiving community mental health care. This work seeks to improve: Adequacy of care networks, appropriateness of reimbursement patterns for providers, and coordination of mental health and other health care. It will be carried out collaboratively by the state agencies with plans and providers.

Expanding housing while reforming models

New York's investment and expertise in community mental health housing leads the nation. Models such as "Housing First" (which recognizes that treatment of homeless individuals with mental illness often cannot commence until they are safely housed) and Single Room Occupancy (SRO) supportive housing programs that provide efficiency apartments with on-site supports have been developed in New York and copied across the country. The path breaking "New York/New York" housing agreements between NYS and NYC will perhaps be considered as a national model, with NYC Housing Commissioner Shaun Donovan the secretary-designate of the Department of Housing and Urban Development (HUD).

But despite these successes, NYS faces enormous challenges in housing for people with mental illness. These individuals are uniformly indigent (85% unemployed, and most relying on Supplemental Security Income (SSI) which provides a monthly subsidy

of about \$700). In most of NYS, basic rental of a one-room apartment costs more than these individuals total income. Worse, the supply of very-affordable housing is eroding due to changes in the housing marketplace. Tens of thousands of people with a mental illness are stuck in hospital units, homeless shelters, adult homes or leaving correctional facilities annually; many more are living with over-extended families or friends.

Additionally, many of the residential services that NYS created over the years (e.g., group homes) have turned out to have limited utility over the long term. Useful for individuals in transition or with significant disabilities, they tend to become de facto permanent housing, because other options for housing or supports are not available.

OMH in collaboration with other agencies and its provider community is working to address these complex challenges. To improve the supply of housing and to reduce reliance on stand-alone mental health housing, we are pursuing joint development of mixed used housing with HFA and DHCR. To improve the flexibility of current arrangements, we are exploring the selective conversion of group homes to permanent supportive housing. All of these developments are proceeding well yet all are exceedingly complex. Financing housing development in a way that viably integrates tax credits, bond funds, private investment and other sources of capital is challenging under the best of circumstances and even more so in a credit crunch. Financing the operation and maintenance costs is just as important and just as complex. Stigma continues to impede and slow

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down housing development, even though the track record demonstrates that supportive housing developments are good neighbors that tend to improve neighborhood property values. And financing the services that individuals need to “make it” in normal housing involves a complex mix of Medicaid, state, local and private funding streams.

Sustaining the development of supportive housing and the reform of finance and support models is much more challenging in an environment of budget cuts and project by project review and approval. In this budget, we nonetheless seek to accomplish this delicate task. Specifically all housing developed under the NY/NY III agreement will proceed as will projects where sites have been secured. Resources appropriated in the 08-09 budget to develop supported housing will be used in part to expand the array of supported housing and in part to create a new and more flexible housing subsidy program during 2010-2011.

Multiple interagency coordination and collaboration initiatives

Although the collaboration between OMH and DOH/Medicaid is critical because of interdependencies related to consumer needs and Medicaid reimbursement, OMH is involved in a dizzying array of other interagency collaborations. These efforts involve a greater number and complexity of collaborative efforts than is typical for most agencies. But they are necessary because people with mental illness are involved in the work of many agencies, including

schools, health care, human services, housing/homelessness, disability/income support and criminal justice agencies, and others. A complete inventory of these efforts is beyond the scope of this testimony, but several examples that are significant and timely deserve mention. These include:

Development and initial implementation of the Children’s (Mental Health) Plan

In October 2008, OMH with eight other child-serving state agencies submitted the first comprehensive Children’s Plan to Governor Paterson and legislative leaders. The Plan was tasked to OMH by the Children’s Mental Health Act of 2006, but completed collaboratively because children’s development and mental health issues are a major concern for every child-serving system. From early educating to parenting, from pediatrics to the schools, from foster care to juvenile justice—children and youth with behavioral problems are a major concern. And in each of these areas, collaboration is required to address the problem. To take just one example, a study by the Yale Child Study Center found that more young children are expelled from preschool settings than from the public schools. The data also shows that the presence of behavioral/mental health consultants in these settings significantly reduces expulsions, allowing children to stay and succeed in the developmental programs they need.

The participating Commissioners from all involved state agencies have continued to meet under the auspices of the Council for Children and Families, with

regular participation by parent and youth advocates. Following submission of the Children's Plan, leadership staff from all the participating agencies have continued to work to develop initial proposals-high urgency but modest cost-to implement recommendations. These proposals, summarized below, share a common element. The solutions will be implemented within the mainstream child-serving agencies, will involve mental health best practices and involvement, and will be collaboratively planned and implemented. Behavioral problems for children are a scourge, and lead to wasted dollars and wasted and even lost lives. These initiatives are exceptionally important efforts allowing NYS to begin to reverse these patterns of neglect, expulsion, violence, institutionalization and even death.

Collaboration among Mental Hygiene agencies

Following the "People First" forums conducted in 2007, the "O" agencies have continued to work more closely together. Efforts have included revitalization of the Inter-Office Coordinating Council (IOCC-chaired by Commissioner Carpenter Palumbo) with a shared electronic template and framework for "5.07 Plans" developed by each county Mental Hygiene department and the state agencies; development of a first ever plan and report by the Most Integrated Setting Services Council (MISSC-chaired by Commissioner Ritter and including other agencies and advocates); and work to improve services to individuals with "co-occurring disorders."

Law enforcement and corrections collaborations

OMH works in close partnership with the Department of Correctional Services (DOCS) and provides the most sophisticated array of mental health services to state prison inmates in the U.S. With a full-service, accredited psychiatric hospital in Marcy NY (the Central NY Psychiatric Center) and services to 8,500 inmates in 50 state correctional facilities, OMH provides a full array of mental health services to the prison population. OMH and DOCS are collaborating in both current service management and future program development. OMH is also working with numerous other agencies to better identify, track, treat and manage sex offenders under the Sex Offender Management and Treatment Act (SOMTA). Under this legislation OMH evaluates and classifies inmates charged with specific sex offenses who may be appropriately subject to "civil management" consisting of either Strict and Intensive Supervision or inpatient civil commitment and treatment in distinct sex offender facilities within OMH hospitals.

Considering the problematic and flawed implementation of sex offender civil commitment programs in many other states, New York's implementation efforts have been well managed. However, in the context of the most extreme budget challenges faced in many decades, considering the high costs of OMH's sex offender program is essential. A very small number of offenders are committed to institutional care at great cost (costs are high because provision of intensive treatment is constitutionally required as a condition of commitment, despite the data showing only limited efficacy of this treatment, and also be-

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In the context of the most extreme budget challenges faced in many decades, considering the extreme costs of OMH's sex offender programs is essential.

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cause extensive security provisions are required). In the 2009-2010 budget, several steps to reduce the costs of the treatment program (to about \$175,000 annually per offender) and to defer the growth in the OMH population (now about 100 individuals/year) are recommended.

Finally, OMH is working with many collaborating state and local partners on efforts to reduce the flow of individuals with a mental illness into the adult and youth correctional systems wherever appropriate. These collaborations are with state and local law enforcement agencies (e.g., to improve training to police officers and police/community mental health collaboration) and with courts (e.g., collaboration with the Office of Court Administration to provide appropriate supports to developing Mental Health Courts in NYS).

Collaboration with administrative and control agencies

These operational collaborations assume additional significance given the multiple requirements for oversight, control, auditing, and inspections of operations in a time of fiscal restraint. In addition to even closer working relationships with the Division of Budget on expenditure controls and review of transactions, other areas of heightened collaboration include: Office of the Medicaid Inspector General (OMIG) on Medicaid billing issues, Department of Civil Service (particularly on obstacles to nurse recruitment and retention that are essential for OMH hospitals to come into compliance with the legislated ban on mandated nurse overtime), and the Office of Information Technology (given the size and complexity of OMH information

systems, and the urgent need to modernize both administrative and clinical records systems, e.g., development of Electronic Medical Records).

Budgeting and management in a fiscal crisis

As Governor Paterson has forcefully and convincingly illustrated, the current economic downturn illustrates a deeper problem: NYS is not living within its means. On multiple fronts (including the largest areas in the budget: School spending and Medicaid) New York's expenditures are comparatively the highest in the country. The current economic crisis merely reveals the continuing and structural nature of this imbalance. We must not only reduce current spending and defer new commitments wherever possible, but also commence or continue the long term restructuring of services to produce better value at lower relative cost.

A long-term look at comparative expenditures for state mental health programs reveals that NYS has already achieved substantial spending controls in mental health especially by shifting the burden of investments away from state general funds. National data on spending of State Mental Health Authorities (SMHA's) shows that in 1981, total mental health spending in NYS was \$69/capita. This was by far the highest level in the country, exceeding the national average (\$27/capita) by 155%. By 1997 NYS mental health spending/capita was \$113. This was still higher than the national average of \$60/capita, but NYS exceeded the national average by "only" 88%. The re-

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duction in New York’s “excess costs” was due to a lower rate of growth than that of most states. By 2006 (the last year for which comparable data is available), OMH spending at \$213/capita was still 88% above the national average of \$113. However, OMH general funds spending was virtually identical to general fund spending in 1997 (about \$1B). The proportion of OMH expenditures from state general funds was 26%, significantly below the national average for general fund support of SMHA operations (46%). Thus compared to other areas of state government, the rate of growth in mental health spending has been both reduced relative to other states, and transferred to other sources (principally Medicaid). Significant shifts and controls in mental health spending have already occurred. Additionally, the shift in revenue sources toward Medicaid highlights the importance of rationalizing the Medicaid/mental health relationship, and indicates that reductions in relative general fund support for mental health care may be reaching a limit.

Budget implications and specifics

Budget Reductions in 2008-2009

While the state spending for mental health care in New York State has been essentially flat for a decade, further reductions were necessary in 2008-09 in response to a worsening budget crisis. Two rounds of reductions were made; the first round of cuts was in the budget itself when it was enacted in April. A second round of cuts was taken at Governor Paterson’s direction (in state operations) and in the special legislative session in August of 2008.

A summary of the cuts and the annualized impact of these reductions follows on page 16.

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Our first commitment
is to sustain core programs,
while deferring cost increases
wherever possible until
they are affordable.
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2008-09 Budget Savings Implemented (Cash in Millions)

First Round—Financial Management Plans

	Budget Actions 2008-09	Annualized Impact 2009-10
Local Assistance		
State Aid Reductions (Sheltered Workshop, LGU Admin, Community Support)	(\$4.2)	(\$5.6)
Medicaid Reductions (COPS and CDT)	(\$0.6)	(\$2.3)
Conversions to Medicaid	(\$2.0)	(\$3.5)
Slowed Program Development	(\$6.1)	(\$2.8)
Delay of New Initiatives	(\$3.3)	(\$2.0)
Local Total	(\$16.2)	(\$16.2)
State Operations		
Facility Related Reductions	(\$8.8)	(\$7.5)
Central Office/Statewide Related Reductions	(\$2.9)	(\$4.3)
Slowed Program Development	(\$1.7)	(\$1.7)
SOMTA	(\$9.7)	--
State Total	(\$23.1)	(\$13.5)
ROUND 1 TOTAL	(\$39.3)	(\$29.7)

**Second Round—State Ops 7% Reductions/
August Special Economic Session**

	Budget Actions 2008-09	Annualized Impact 2009-10
Local Assistance		
Further Delay of New Initiatives	(\$0.8)	--
6% Cut Legislative Program Adds	(\$0.1)	--
Additional Local Assistance Reductions	(\$1.9)	(\$7.3)
Local Total	(\$2.8)	(\$7.3)
State Operations		
Facility Related Reductions	(\$16.0)	(\$24.1)
Central Office/Statewide Related Reductions and Revenue Enhancements	(\$41.6)	(\$31.1)
Delays in Forensic Initiatives/SOMTA Adj.	(\$5.9)	(\$4.1)
Eliminate NKI Legislative Program Add	(\$1.5)	(\$1.5)
State Total	(\$65.0)	(\$60.8)
ROUND 2 TOTAL	(\$67.8)	(\$68.1)

2008-09 Budget Savings Summary

	Budget Actions 2008-09	Annualized Impact 2009-10
First Round Total	(\$39.3)	(\$29.7)
Second Round Total	(\$67.8)	(\$68.1)
Grand Total	(\$107.1)	(\$97.8)

Proposed Budget 2009-2010

Trends in controlling state spending and the cuts already made do not mean that cuts in mental health spending are impossible. Rather, it illustrates the difficulty and challenges inherent in this necessary task. Viewed in the context of OMH's overall reform agenda ("everything changing, simultaneously") it calls for clear priorities and sound management. Our strategy rests on three fundamental tenets:

- ◆ We must sustain an aggressive change agenda, balanced by thoughtful management and attention to the challenges of change;
- ◆ We must maintain the quality of care and the pace of reform in the context of a staff freeze, resource limits, and heightened oversight controls;
- ◆ We must continuously collaborate and communicate: Internally, laterally, and with all stakeholders

These principles lead directly to the 2009-2010 budget proposal. Savings and reallocations in the mental health budget and the annualized impact of the proposed actions are illustrated in the tables on page 18. When it comes to spending and costs, our first commitment is to sustain core programs, while deferring cost increases wherever possible until they are affordable. We would rather get by with what we have than make new investments on the one hand while cutting existing services on the other. This has several tangible implications. Generally, new pro-

grams authorized in previous budgets but not "up and running" will be deferred unless they are crucial to our core commitments or necessary to save money. Additionally, new expenditures will be deferred even if they are important. Examples include deferring or reducing Cost of Living Adjustments (COLA's), deferring community residential program enhancements, and the Governor's proposal to defer negotiated salary increases. These adjustments are needed and should be provided, but must be done in the context of the State's current fiscal situation and in light of the need to preserve funding for core services.

A corollary of this approach recognizes that most of the change that is needed in our system is likely to follow "bottom-up" innovations and improvements initiated by local leaders—just as the real progress in mental health recovery occurs because of the efforts of individual consumers. This is a paradox of change; too often, endless top-down management or policy directives leave people "dazed and confused;" whereas taking the initiative to make a personal, programmatic or agency change depends on stability and confidence. Thus, we view protecting the "base" of core mental health services (both in State Operations and in local programs) as essential to making changes that lie ahead. From improved efficiency and responsiveness of OMH hospitals, to more responsive housing and residential services, to the adoption of recovery- and resiliency driven approaches, providing a predictable resource environment is essential.

A second major approach in 2009—2010 is to restructure programs for efficiency or savings while retaining capacity. Several examples illustrate this

From improved efficiency and responsiveness of OMH hospitals, to more responsive housing and residential services, to the adoption of recovery— and resiliency driven approaches, providing a predictable resource environment is essential.

2009-10 Executive Budget Savings and Reallocations (Cash in Millions)

Local Assistance

	Budget Actions 2009-10	Annualized Impact 2010-11
Proposed Savings		
Defer COLA Trends	(\$67.1)	(\$67.9)
Local Assistance Reductions	(\$4.6)	(\$5.1)
Maximize Recoveries	(\$8.5)	(\$8.5)
Freeze Residential Pipeline Beds	(\$6.0)	(\$6.0)
Defer/Restructure New Commitments	(\$17.1)	(\$9.5)
Local Total	(\$103.3)	(\$97.0)
Annualization of CDT Restructuring (DOH)	(\$8.5)	(\$8.5)
Local Total w/ DOH	(\$111.8)	(\$105.5)
Proposed Reallocations		
Children's Plan	\$1.7	\$3.0
Peer Support initiative	\$0.7	\$1.4
Medicare Eligibility Demo	\$0.5	--
CDT Restructuring Conversions	\$6.0	\$6.0
OMH Indigent Care Pool	\$5.0	\$10.0
Local Total	\$13.9	\$20.4
Local Net Change*	(\$89.4)	(\$76.6)

*Excludes DOH savings

State Operations

	Budget Actions 2009-10	Annualized Impact 2010-11
Proposed Savings		
Facility Related Reductions	(\$8.6)	(\$13.0)
Central Office/Statewide Related Reductions	(\$14.3)	(\$15.3)
Delays in Forensic Initiatives/SOMTA Adj.	(\$22.9)	(\$30.0)
State Total	(\$45.8)	(\$58.3)
State Change	(\$45.5)	(\$58.3)

2009-10 Budget Savings Summary

	Budget Actions 2009-10	Annualized Impact 2010-11
Total OMH Net Change	(\$134.9)	(\$134.9)

approach. In the OMH SOMTA programs, *we reduce staffing patterns to levels in some of our other forensic services* (at an estimated cost/bed of \$175,000, these costs will still be among the highest in the country—but we are unwilling to reduce staffing and costs to risky levels). In our prison mental health programs—already the most robust in the country—we will defer some new investments. In OMH adult Psychiatric Centers, *we close several units in hospitals where the patient census has already declined or will decline due to planned placements* (Thus we are closing vacant, unneeded beds, and redeploying some staff—such as RN’s—to cover urgent needs, while relying on attrition, the job freeze and careful management to reduce overall staffing). Additionally, in most of the adult Psychiatric Centers, *we will create a Transitional Placement Program, with increased community exposure and modestly reduced clinical staffing*. This approach, similar to what many general hospitals have done in converting inpatient to rehabilitation beds, should help eligible patients prepare for transition to a more appropriate, less costly community program, while allowing us to better utilize some staff (again, especially RN’s) in key posts where they are needed.

In community programs, reductions in the reimbursement rate paid to providers of Continued Day Treatment (CDT) programs will help balance the budget. While budget reductions in CDT do not mandate reductions in capacity, OMH will work with providers that wish to transition to more sustainable program models. We do not (as Massachusetts has just done) seek to dramatically reduce capacity of this program which is a dated model that, nonetheless, provides essential supervision in some

communities. We will work with providers who may seek to transition their current CDT programs in the direction of more efficient clinic models, or the rehabilitation-oriented Personalized Recovery Oriented Services (PROS). Because PROS is crucial to reform (e.g., the urgent necessity of assisting participants to find a job), a small increase in PROS employment resources provided in the 2008-2009 budget is included in the proposed budget.

Modest, transformational investments

Even in a challenging budget environment, some challenges call for small and catalytic investments. Our criteria for these investments are that they represent urgently important change which is unlikely to occur otherwise and where small investments can lead to and leverage larger and more robust reforms. Two such reform initiatives are proposed in this budget, one involving children and the other, adults.

Initial implementation of recommendations from the Children’s Plan

Acting on the first-ever Children’s (Mental Health) Plan—one of the first formal state-wide and interagency plans to focus on children’s behavioral health, nationally—demands small and catalytic investments. These are collaboratively developed proposals to better treat and prevent behavioral problems in mainstream settings where most children are served. Some recommendations can be advanced within existing resources (for example, better connections to

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Joint Initiative	Child-Serving Agencies	Implementation Start
Increase access to information on social and emotional development and learning	All	Spring 2009
Training and consultation in the identification and treatment of emotional disturbances in children.	DOH, OASAS, OCFS, CCF and OMH	Spring 2009
Integrated treatment models for children with co-occurring disorders and/or children in foster care or DJJJOY	OASAS, OMRDD, OCFS, DJJJOY and OMH	2008
Expand Clinic-Plus to targeted high need schools and probation	State Education, Probation and OMH	October 2009
Improve educational outcomes for students in state operated psychiatric hospitals.	State Education and OMH	January 2009
Prioritize Child Psychiatry under the “Doctors Across New York (DANY) legislation, the Department of Health will develop criteria	DOH and OMH	2010
The Children’s Commissioner’s Workgroup commits to an aggressive effort to improve access to appropriate care for children who require services from multiple agencies and defines global positive outcomes	All (Council of Children and Families lead)	Ongoing

mental health care for children referred for special education emotional disturbance issues). Others will be supported through reinvestment of current resources. Examples of the joint initiatives are provided above.

Facilitating employment and peer support among adult mental health service recipients

One of the greatest tragedies of mental illness is how it too often interferes with or even halts productive employment, development of careers, and economic independence. The data show greater unemployment among adults with serious mental illness than any disability group, 85% unemployment among

adult service recipients of NYS mental health services, and \$193B in annual lost wages due to mental illness (an estimated \$12B in NYS alone). This dismal performance is due in large measure to effects of the illness itself: It can cause “invisible disability” with an unpredictable course, and interrupt lives just as people transition to adulthood. But it is also due to a host of factors that we can and must address: A focus in mental health care must be on getting a life not just managing symptoms, educating both consumers and professionals that there are ways to work and still receive essential benefits (e.g., Medicaid), and better cooperation with private business and workforce professionals.

These goals will be addressed under a multi-year Medicaid Infrastructure Grant (MIG) obtained by OMH under the auspices of the MISSC. The grant is a \$6M/year cross-disability employment initiative funded by the federal Centers for Medicare and Medicaid Services; we focus here on the mental health implications. The project will be advanced in collaboration with employment and disability experts at Cornell and Syracuse Universities. Key strategies include collaboration with employer groups, better use of benefits that facilitate employment, and development of an interagency statewide plan to increase employment opportunities and economic independence for people with disabilities.

A second project will help us improve and expand supports that are provided to people in recovery by people in recovery. Here, the mental health system lags behind addiction recovery. However, The Surgeon General's landmark 1999 report on mental health notes the effectiveness of self help and peer support. New York has a diverse consumer/survivor/recipient community, but much more can be done. With resources (\$.7M) in the 2009-2010 budget, we will initiate a peer leadership development effort that will train and support consumers for leadership roles across NYS. This effort will be supplemented with another smaller federal grant that will help us determine and document the sustainable best practices for consumer operated "recovery centers" that provide an invigorating complement and alternative to traditional mental health services.

Conclusion

Governor Paterson's proposed OMH budget for 2009-2010 reflects a fair, thoughtful and tough approach to New York's substantial mental health obligations. It significantly curtails spending (in conjunction with reductions implemented in the 2008-2009 budget, mental health spending will be reduced over \$230M from levels originally anticipated in that budget). It preserves our ability to deliver on core obligations to some of the state's neediest citizens, while restructuring many programs to improve quality, efficiency and access. It defers costs for investments that-though desirable-simply cannot be afforded at this time. And it makes small but essential investments that will help transform mental health care for children toward achieving resilience, and for adults toward recovery and economic independence.

We look forward to the dialogue needed to address concerns, increase our mutual understanding, and make a good budget proposal potentially even better.

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