

# 2010-2011 Office of Mental Health Update and Executive Budget Testimony

**G**overnor Paterson’s Executive Budget Recommendation for the Office of Mental Health (OMH) for 2010-2011 is tough and fair. It institutes key reforms to put New York on the road to economic and fiscal recovery. It demands that OMH remain focused on finding solutions to many challenges in mental health care and to maintain a high quality of care. If we maintain focus, the resources the Governor has proposed are adequate. But, there is little margin for error, and no room to reduce the Governor’s Recommendation. In this testimony, I will outline why mental health care is so important for New Yorkers, highlight progress we have made, and discuss the challenges we face to implement this Budget.

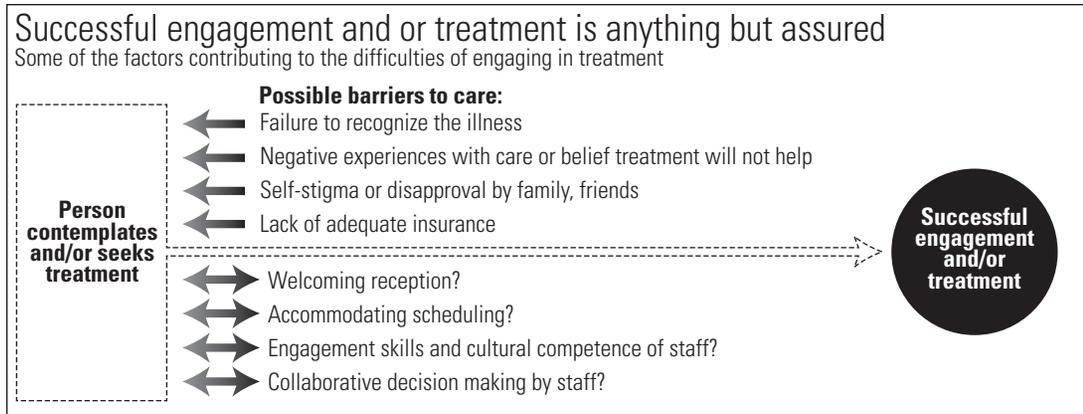
## Mental Illness is Widespread and Disabling

Mental disorders are common. Every year, more than one in five New Yorkers has symptoms of a mental disorder. In any year, one in 10—adults and children—has mental health challenges serious enough to affect functioning in their family, at work or school. Mental illness accounts for more than 15 percent of the burden of disease (total cost), exceeding the disease burden caused by all cancers.

Despite these compelling facts, the stigma of mental illness—and the discrimination that

results—continues to hinder treatment and stands in the way of an adequate response. Getting good care is often like running a series of hurdles. The obstacles include symptoms that can reduce one’s ability to recognize the problem, the stigma attached to receiving treatment, insurance limits, challenges in finding the right therapist or treatment, and staying engaged in care when relief does not come quickly.

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These barriers add up. On average, in the United States, people enter care nine years after problems first appear. We also now understand the significance of mental health problems as the leading health challenge for children; half of all lifetime cases of mental illness begin by age 14, while three-quarters begin by age 24. Mental disorders that appear early on, when left untreated, are associated with disability, school failure, teenage child-bearing, unstable employment, marital instability, death by suicide, and violence.

Delays in entering care, or not receiving it at all, result in staggering invisible costs of mental illness. Nearly \$200 billion is lost in reduced earnings due to mental health problems each year nationwide. The excess costs of untreated or poorly treated mental illness in the disability system, in prisons, and on the streets are part of the mental health care crisis. We have been spending too much on treating mental illness in its debilitating late stages, and not enough in early and effective care.

Despite the difficult times we are in, addressing the cost of mental illness must be part of New York's recovery agenda. We must sustain safe, quality care while controlling costs. We must continue reforms that improve quality, fairness and accountability. The underpinnings of good care are early access, clinical and cultural competence that considers individual needs, continuity and integration of care, and a focus on practical goals (helping people to live, learn and work productively in their communities) rather than just treating symptoms.

## The Core Mission of OMH: Sustain the Mental Health Safety Net

The majority of people in New York who find treatment for their mental health problems do not receive it in State psychiatric hospitals or even in OMH operated, funded, or regulated program. Instead, individuals often see private therapists, rely on self-help and peer support, or simply receive medication treatment from pediatricians, geriatric specialists or other primary care physicians. Sometimes these alternatives are sufficient. For those people whose illness is complex or results in substantial disability—or for those who lack insurance coverage or have inadequate mental health benefits—more is often required. This is where the OMH “safety net” is essential.

### **The OMH Safety Net Provides Care for People Most Affected by Mental Illnesses**

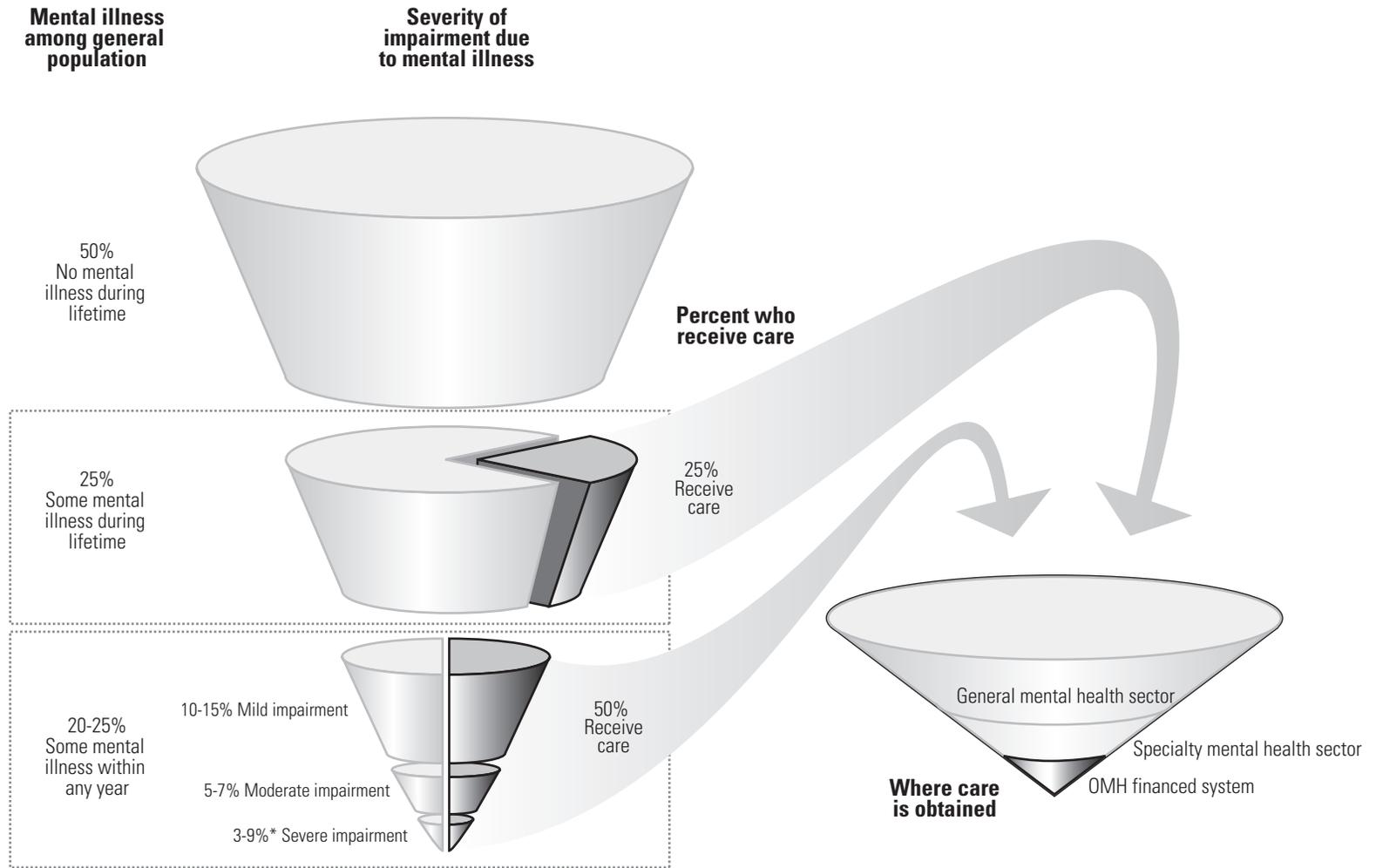
When people with mental illness cannot afford private care or when the illness results in disability, people tend to “fall into” the safety net of programs operated by non-profits, counties, hospitals and the State. The core mission of OMH is to sustain and build this safety net for adults living with serious mental illness, and children and youth with serious emotional disturbance. This role is consistent with the central role of government: to provide support for those who

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need it most. In tough times, when rates of mental illness and suicide increase and private care can be less accessible, this challenge is urgently important.

While mental health care in the general medical sector is more convenient and less stigmatizing, it is not always available and does not always work. Part of OMH's role is to encourage and support the larger health system to do its job with respect to mental health care. Medical doctors are often neither trained nor reimbursed adequately to provide the best care for mental illness. Our work with the American Academy of Pediatrics, as a part of The Children's Plan, illustrates this priority. While working to improve access to mental health care within the health system is timely given Timothy's Law and possible national reform, our most fundamental priority is to sustain an accessible and competent public mental health system.

# Patterns of mental illness and mental health care



\* Rate for children is 5-9%. Rate for adults is 3-5%.

## Governor Paterson's 2010-2011 Budget Proposal Sustains the Mental Health Safety Net

The Governor's Budget, while imposing significant savings, is sufficient to preserve the essential services that make up the mental health safety net, both with respect to State-operated facilities and local assistance/community programs. The core of this approach is:

1. Providing adequate resources to maintain quality and access in State-operated hospitals and outpatient programs, including those serving inmates in Department of Correctional Services (DOCS) prisons
2. Providing Local Assistance resources including Medicaid support to allow us to reform and sustain outpatient clinic services, to convert other outpatient programs to the Personalized Recovery-Oriented Services (PROS) model, and to preserve housing programs that provide a foundation for recovery

OMH has already taken substantial cuts since 2008 and as part of the Deficit Reduction Plan in 2009-2010. Fortunately, we have been able to manage those cuts carefully and few programs have been seriously impacted. While poor access to care is a problem, we have worked hard to prevent further erosion, making support for Governor Paterson's Proposed Budget for OMH all the more imperative.

## Mental Health Update: Sustaining Quality and Reform in Tough Times

Our mental health system faces the greatest challenges of its time. Yet, the work of helping people recover from illness and build meaningful, productive lives in their communities goes on. While this Budget initiates no new services, it will not seriously disrupt or stall the essential reforms that are under way in New York.

### **Improving the Productivity and Focus of OMH Hospitals**

Over the past 50 years, the public mental health system in New York has evolved from one dominated by large State psychiatric hospitals serving a tiny fraction of those with serious mental illness, to a highly dispersed system of non-profit organizations, county mental hygiene departments, and State and private hospitals serving about 650,000 individuals yearly. Currently, OMH funds and/or licenses more than 2,500 mental health programs operated by local governments and private agencies. They provide outpatient, inpatient, emergency, residential, community support and vocational care and services.

OMH is the only State agency to operate a substantial network of accredited hospitals serving children, adults and court-involved (forensic) patients—all with the most intractable mental illness. These hospitals (psy-

chiatric centers) provide both inpatient treatment and community care programs that serve as a backup to local community programs. (Within the DOCS-run State prison system, OMH provides hospital care at Central New York Psychiatric Center and outpatient programs within many DOCS facilities.) Most OMH State operations resources are devoted to adult services, with a capacity of about 3,600 current hospital beds and more than 20,000 individuals cared for in community programs.

Overall, New York seeks to meet most of the need for brief hospital care in general hospital units; the OMH facilities provide “backup” intermediate- and long-term care that represents the ultimate safety net. This division of labor is encouraged by Medicaid rules that reimburse psychiatric care for adults within medical centers, but not within State-operated or Article 31 psychiatric hospitals. Access to hospital psychiatric care when it is most needed—in the context of acute illness—is at risk in today's health care environment. Mental health care is often not valued or reimbursed on an equal basis within hospitals, and there is an emerging trend among general hospitals to close psychiatric units. OMH is responding to this challenge by improving access to its State hospitals.

Last year, OMH began a series of focused actions to improve the efficiency and productivity within its hospitals and to increase access to acute care. It built on successes from 2008 where admissions to adult hospitals increased modestly, while showing a decline in census. During 2009, adult hospitals admitted 4,644 individuals into about 3,600 beds. This

# New York State Office of Mental Health Psychiatric Centers and Research Facilities

- Adult Psychiatric Center
- Adult/Child Psychiatric Center
- Adult Psychiatric Center with SVP
- Children's Psychiatric Center
- ▲ Forensic Psychiatric Center
- ★ Psychiatric Research Facility



represents 425 more admissions than in 2008, an increase of 10.1 percent (and an increase of 27.8 percent over the 3,634 admissions in 2007). These gains have occurred with fewer beds and with substantial reductions in overtime among staff, reflecting increased productivity and efficiency in hospital operations.

These gains in access have occurred in part by reducing very long-term hospitalization (lasting over a year), which is extremely expensive and often counterproductive. People who are long hospitalized can become dependent on institutional life. OMH is addressing this challenge in part via a new residential approach in many of the adult psychiatric centers. The Transitional Placement Program (TPP) is designed to aid the transition to community care for persons who have received maximum benefit from inpatient treatment, but need help moving to community care. By the end of this fiscal year, we will have converted 325 hospital unit beds to TPPs; the 2010-2011 Budget Recommendation calls for further limited development of transitional capacity. In addition to OMH efforts to increase access to hospital care, we are working with the Department of Health (DOH) to revise Medicaid hospital inpatient reimbursement so that it is fairer and rewards good care.

OMH is also working to improve the focus, effectiveness, value and efficiency of its hospital-operated community services. We are working with local mental hygiene directors and others to ensure that outpatient programs deliver value and are complementary to services provided by community agencies.

Sustaining the quality of care in these times is very difficult. Moreover, while additional constraints have been imposed, OMH is coping with eroded staffing, challenges in recruiting and retaining psychiatric nurses and psychiatrists, leadership retirements, increased service expectations, and tougher accreditation/certification expectations. OMH is now engaged in intensive review of the quality, staffing and leadership in every hospital to allow us to meet these challenges. The Governor's Proposed Budget for 2010-2011 will allow us to sustain and strengthen vital hospital services.

### **Reforming Mental Health Clinic Financing**

OMH continues to focus on financing reform in tandem with improving service delivery. Our immediate challenge is implementing reform in the financing of mental health clinic services, as required by the 2009-2010 Budget. The current clinic ap-

proach is outdated and out of step with quality expectations. It necessitates changes to adhere to federal billing and Medicaid requirements. Thus, reform is needed for quality, fairness, and consistency with federal requirements and for sustaining current investment levels. It will support an improved model of care, which was designed with significant stakeholder participation and input at every step of the way.

The reform plan encompasses five key elements:

1. *Redefined and more responsive set of clinic treatment services and greater accountability for outcomes*

Clinic care is a level of care analogous to that provided by physician practices or medical/health clinics in the health system. Within this level of care, specific services that are encouraged and reimbursed include outreach, evaluation, individual and group therapy, and medication management. Clinic treatment—like primary care

#### **Discrete Clinic Services Reimbursement APG Methodology**

##### ***Required Services***

- Outreach and Engagement
- Initial Medical Assessment/Health Screening
- Psychiatric Assessment
- Crisis Intervention
- Psychotropic Medication Administration
- Psychotropic Medication Treatment
- Psychotherapy (individual/group/family/collaterals)
- Complex Care Management

##### ***Optional Services***

- Psychotropic Medication Administration for Children
- Developmental and Psychological Testing
- Wellness Screening and Monitoring (to reduce co-morbid illness risk associated with mental illness and its treatment)
- Offsite Psychiatric Consultation

in the health system—is the foundation of the mental health system, which includes other services, such as case management, vocational support and inpatient care. Paying for those specific services that are needed within clinics is a dramatic improvement over the current “threshold visit” method, which makes payments that are consistent for widely variable services within a clinic, but inconsistent for equivalent services across different clinics.

2. *Increased, consistent Medicaid clinic rates and phase out of “COPs”*

The complex Comprehensive Outpatient Services (COPs) supplemental rate strategy was developed about 20 years ago to provide Medicaid coverage as an alternative to general fund budget cuts. COPs is a complicated “workaround” that has become a dominant and dysfunctional financing model. Under reform, payments will be comparable for similar services delivered by similar providers, adjusted for the cost of providing services. Called Ambulatory Patient Groups (APGs), the new outpatient reimbursement methodology parallels the same methodology for medical outpatient services and provides for necessary consistency across outpatient programs supported by DOH and the Mental Hygiene agencies. Payments targeted to costs and service intensity will replace the mental health “threshold visit” methodology for reimbursement, under which physician and therapist services, as well as complex assessments and simple interventions, have all been paid at the same level in the same agency (with widely variable payments for equivalent services in neighboring clinics).

3. *HIPAA-compliant, procedure-based payment system*

The federal Health Insurance Portability and Accountability Act (HIPAA) sets national standards for electronic health care transactions and billing. Under reform, billing for clinic services will be HIPAA compliant. Reform will allow payment to reflect differences in costs for services, such as those offered during night and weekend hours or in languages other than English.

4. *Managed care underpayments*

Medicaid managed care, Family Health Plus and Child Health Plus (CHP) plans frequently underpay for mental health clinic services. The average managed care payment for clinic services is approximately one-third to one-half of actual cost. This is significant because Medicaid managed care alone (not including CHP) represents 12 percent of clinic visits, a figure that will grow as the State expands managed care enrollment. To ensure continued access to clinic services, OMH is working with DOH to address payment and access issues for consumers in health plans.

5. *Indigent care provisions*

Assuring access for the uninsured to mental health clinic services is essential. As part of restructuring, the State has formally requested a federal match for the existing State-funded indigent care pool for Diagnostic and Treatment Centers. Under the waiver, access to reimbursement for indigent care will expand to include freestanding OMH-licensed mental

health clinics. Funding from the pool will support care to uninsured middle class and working poor individuals and families who receive care at OMH-licensed clinic sites.

The new reform plan begins this spring and will be phased in over four years, very gradually replacing COPs. This gradual phase-in provides time for providers to adjust. It will also allow for assessment of impact and for OMH to make any necessary “mid-course” corrections.

As necessary reform of OMH payment for clinic services proceeds, the mental health community remains concerned about the ability of families with private insurance and those with no insurance to access mental health services for themselves and their children. Timothy’s Law and federal parity requirements have helped, but many barriers still exist. Insurers must do a better job of assuring access to needed mental health services.

### **Urgent Services Priorities**

Three areas of intense concern and activity are the emotional and mental health of New York’s children (which we address through The Children’s Plan), reducing fragmentation and improving service integration, and housing for people with a mental illness, where efforts are sustained by the Governor’s Proposed Budget.

## Implementation of The Children's Plan

In August 2009, Governor Paterson signed an amendment to the Children's Mental Health Act of 2006 that reflects the evolving nature of the Plan from one that focuses solely on mental health to one that takes into account a more holistic view of children's social emotional development and learning. The amendment recognizes and makes formal the involvement of the nine State child-caring agencies and family and youth partners and places the role of coordinating the specific recommendations of the plan within the Council on Children and Families (CCF). It underscores the importance of creating shared approaches across systems of care that strengthen social emotional development, promote resilience, and prevent mental health problems from developing later in life.

Legislative support is crucial to implementing The Children's Plan and to reform of children's services. Through interagency and stakeholder collaboration, we are making strides—from offering training and support to pediatricians and other primary care physicians so they may better identify and treat children with serious mental health challenges to fostering strong youth leadership that gives rise to the youth voice in policy development and service provision across child-serving systems.

Implementation of the Plan benefits from the leadership of CCF, and the ongoing guidance of the State Commissioners' Committee on Cross-Systems Services for Children and Youth. Senior staff from participating agencies meet monthly between the quarterly meet-

There is strong evidence linking social-emotional health in the early childhood years (birth to 6) to subsequent school success and health in preteen and teen years, and to long term health and wellbeing in adulthood. However, research also shows that effective programs that address social-emotional health early in life can promote resilience and actually prevent mental health problems later in life.

— *National Center for Children in Poverty*

ings of the Committee and oversee day-to-day implementation of the nearly two dozen modestly funded, cross-system Children's Plan initiatives. These efforts aim to strengthen child and family resilience and reverse patterns of maltreatment, neglect, school expulsion, academic failure, violence, substance use, institutionalization and premature death. As part of the OMH contribution to this ongoing effort, we will be gradually phasing in family support services to Child and Family Clinic-Plus this year. These services are crucial in helping parents navigate the intricate system of care and partner with clinical staff; their implementation has been phased back, in recognition of the difficult budget environment.

Two major initiatives begun this year to advance goals of The Children's Plan are:

- ◆ *Creating Promise Zones*  
“Promise Zones” are community collaborations in which local school districts partner with State and local child-serving

agencies to create healthy and engaging learning environments, with a focus on the highest-need schools. The major goals are to reduce absences, truancy and classroom incidents, while providing teachers with more time for student learning and better educational outcomes. OMH, CCF, the State Education Department, Office of Children and Family Services, and Division of Criminal Justice Services are working with schools in Buffalo, Syracuse and the Bronx to develop plans to support and replicate Promise Zones in their communities.

- ◆ *Promoting education and consultation services for pediatricians and primary care physicians*  
OMH has formed a partnership with DOH, American Academy of Pediatrics, American Academy of Family Physicians, and the New York State Conference of Local Mental Hygiene Directors to implement the first phase of a planned statewide program comprised of three interrelated services. These include child and adolescent psychiatric consultation, linkage with community-based services, and pediatrician and primary care physician training and education. The intent is to respond to the shortage of child psychiatrists and create a solid platform statewide for better identifying, treating and making appropriate referrals to specialty care for children with social emotional challenges and their families.

## Better Integration of Care and Focus on Wellness

People with mental illness get other illnesses and diseases as well. These other health problems, however, are even more challenging to individuals with serious mental illness. Nicotine dependence, lung and cardiovascular disease, obesity, hyperlipidemia and other effects linked to psychiatric medication treatment are not unusual. Moreover, people with the most serious mental illnesses can fall through the cracks between multiple providers and experience lapses in care that put them at even greater risk of bad health outcomes. For these reasons, OMH has continued efforts to better integrate care. A number of projects continue to address these urgent concerns, including:

### ◆ *Coordination of care pilot projects*

The Proposed Budget continues funding for care coordination pilot programs in New York City and Western New York. Integrated Wellness Partners is leading the City program in partnership with ten major behavioral health providers. The intent is to create a recovery-based approach to integrating mental health and health care delivery so that it is cost-effective and leads to improved health outcomes.

The Western New York Care Coordination Program works toward the same goal. Recent progress includes streamlined application processes for case management and housing services; preparations to introduce complex care management for 400 persons with intensive mental, physical and chemical dependency needs; and development of

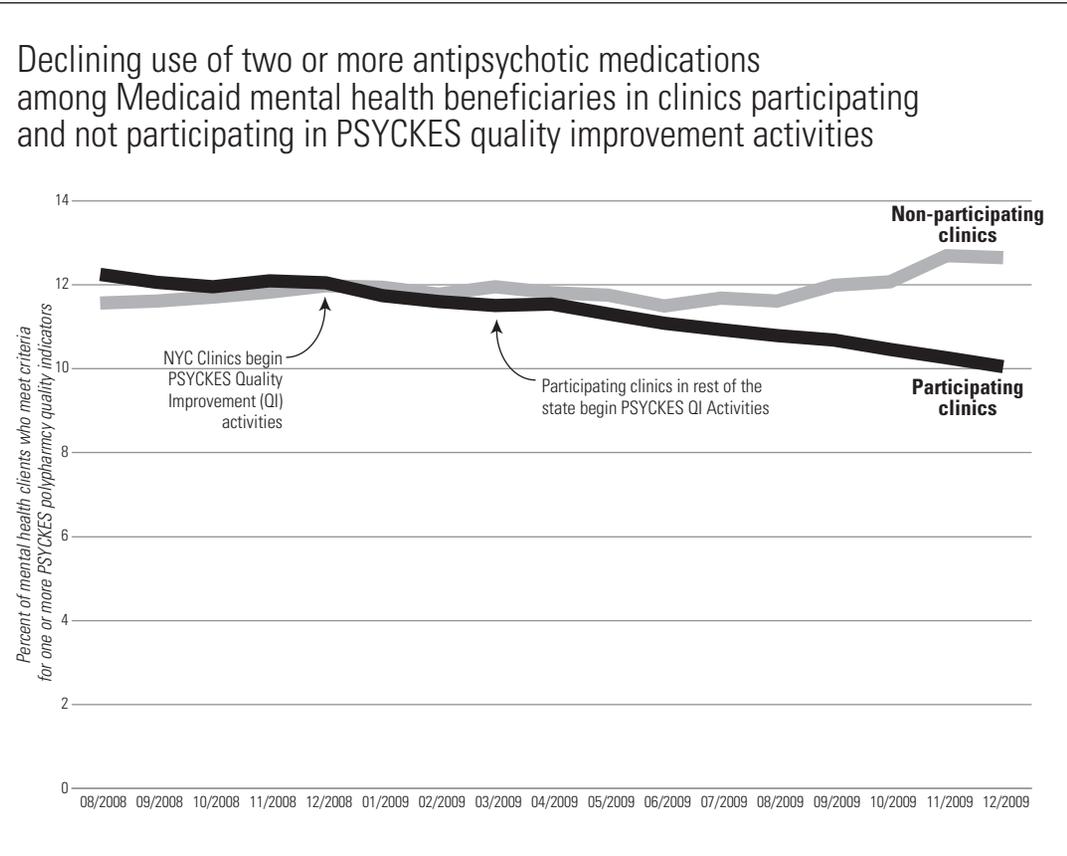
fiscal incentives for achievement of quality care and fidelity to person-centered care.

Other important care coordination projects are also taking place across the State. They include two major pilot programs funded through the Geriatric Mental Health Act. Gatekeeper demonstrations in three counties are helping to identify and connect to services at-risk older adults. Seven programs are examining integrated care models with the co-location of mental health

specialists within primary care settings or improved collaboration between separate providers. The demonstrations seek to fully utilize Medicare resources to meet the health services needs of older adults.

### ◆ *Improved prescribing practices*

In partnership with DOH, OMH continues strong leadership in the delivery of quality medication prescribing practices based on the latest scientific knowledge. The vehicle for this effort is the Psychi-



atric Clinical Knowledge Exchange System (PSYCKES), a nationally recognized clinical decision-making and quality improvement tool now in use among State-operated psychiatric hospitals and nearly 350 licensed outpatient clinics serving Medicaid beneficiaries. Using Medicaid data, clinicians are focusing on the appropriate use of multiple medicines to manage serious mental illness and the reduction of risk from cardio-metabolic conditions associated with medication use, including diabetes, obesity, hypertension, and elevated lipid levels. Continuing medical education courses are guiding clinicians in providing quality care and contributing to improved health and mental health outcomes for persons with serious mental illness.

Currently, a consumer version of the tool, called MyPSYCKES, is under development to enable individuals to be full, effective participants in their mental health care. It will provide them with access to their personal medication histories and an online library of health and mental health resources. External funding has been secured to support testing and implementation of MyPSYCKES, which should aid consumers in discussing the pros and cons of specific medications, use of medication therapy to enhance recovery goals, and the detection and management of side effects.

◆ *Intensive care monitoring*

In the wake of several highly publicized violent incidents involving individuals with mental illnesses, the New York State Governor and New York City Mayor con-

vened a panel in 2008 to examine such cases, consider opinions of experts, and recommend actions to improve services and promote the safety of all New Yorkers. The Panel recommended the development of a database to monitor and follow-up on problems in care—for instance, frequent use of emergency department care—for people with substantial histories of mental health care who could benefit from intensive care.

Over the past year, the New York City Mental Health Care Monitoring Project has identified risk groups for screening, created a data system to flag gaps in services, engaged with an expert behavioral

**Care Monitoring in Action—An Example**

A recipient who received case management services in early 2009 had no record of recent outpatient mental health services. When contacted by the Care Monitoring Team, the case management program indicated that the client left services to move to another state. It had not confirmed, however, that the recipient made the transition to a new provider.

The case management program followed up with the individual who had since returned to New York and was homeless and living in a van. The recipient expressed gratitude for outreach and indicated a desire to re-engage in services. The recipient is now in services with the program.

health organization, built support with stakeholders and the community, and launched its first borough care monitoring team in Brooklyn. Between April and June 2010 a second team will launch, an ensuing project evaluation will guide program modifications, and in January 2011, the project will operate fully in the five City boroughs.

◆ *Enhanced care coordination for persons enrolled in health maintenance organizations (HMOs)*

DOH and OMH continue their collaboration to improve care for people in HMOs who receive community mental health care. The collaboration, which extends to plans and providers, is examining the adequacy of care networks, appropriateness of reimbursement patterns for providers, and coordination of mental health and other health care. This work is especially important because of the vital need to address the co-morbid illness and complex needs of people with serious mental illness.

◆ *Improving care for people with co-occurring mental health and alcohol/drug problems*

People with dual disorders have a much better chance of recovery from both disorders when they receive integrated mental health and substance abuse treatment from the same clinician or treatment team. Success, however, hinges on having care delivered by either mental health or addiction treatment providers who have the right training and support. Both State agencies continue to promote integrated care, and provide ongoing guidance on how it can be

done in both OMH- and OASAS-licensed settings. The New York State Health Foundation has provided funding for the Center for Excellence in Integrated Care (CEIC) which is providing technical assistance to providers. Governor Paterson's Budget provides resources to allow this important initiative to continue, by supporting the hands-on training that mental health providers must have to treat co-occurring substance use problems, and vice versa.

### Expanding and reforming housing

Demand continues to outstrip the supply of affordable housing in New York for persons with serious mental illness. While the State has led the nation in creating housing solutions (with about 33,000 units), we are now in a very challenging environment. Our successes have been substantial: the internationally recognized "Housing First" approach, single-room occupancy supportive housing programs, and the New York/New York housing agreements. Stable housing linked to supports provides a foundation that helps people with serious illness succeed, engage in treatment and community life, and recover.

The link between disability and housing problems is glaring. People with serious mental illness and disability often must rely upon Social Security Income (SSI); this contributes to their being among the poorest people in New York and nationally. In 2008, the annual income of a single American receiving SSI was nearly 30 percent below the federal poverty level of \$10,400. Between 1998 and

The lack of decent, safe, affordable, and integrated housing is one of the most significant barriers to full participation in community life for people with serious mental illnesses.

The shortage of affordable housing and accompanying support services causes people with serious mental illnesses to cycle among jails, institutions, shelters, and the streets; to remain unnecessarily in institutions, . . . to live in seriously sub-standard housing [or to be] repeatedly homeless or . . . homeless for long periods of time.

— 2003 *New Freedom Commission on Mental Health*

2008, the gap between housing rents and SSI increased markedly by 62 percent for a modest one-bedroom unit and 71 percent for a studio apartment. In fact, the average percent of SSI needed to rent a single-room unit in New York in 2008 was 141 percent and 129 percent for an efficiency unit. Between 2002 and 2007, according to the Furman Center at New York University, the supply of housing affordable to low-income individuals (not the very poor, but those with incomes less than about \$24,000 annually, almost three times as much as SSI Level I provides) in New York City fell by about 10 percent or 40,000 units. Tellingly, this loss of affordable private housing units in NYC was greater than the supply of all OMH-supported housing and residential programs statewide (about 33,000 units/

beds). The result of this erosion in the housing market is that thousands of persons with serious mental illness have trouble finding places to live in the community.

Reducing reliance on more costly traditional mental health housing models and improving the supply of supportive housing are top priorities for OMH. We maintain our strong collaborations to pursue joint development of mixed-use housing with the State Housing Financing Authority (HFA), the Division of Housing and Community Renewal (DHCR), and the provider community.

This past year, supportive housing rental units for persons with psychiatric disabilities opened in several communities. Governor Paterson's Proposed Budget does as much as possible in this difficult budget

environment to continue momentum in mental health housing development. It provides the resources needed for newly established housing programs and those that are under development under the New York/New York III agreement or are shovel ready. No new housing programs are proposed. The Governor's Executive Budget also recommends resources (about \$1M—the only new initiative in the OMH Budget) to commence assessments and education of individuals with psychiatric disabilities living in adult homes, as the first year of a proposed multi-year remedial plan responding to a federal court decision.

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## Continuing Efforts: Interagency Coordination and Collaboration

As crucial is our collaboration with DOH, so too are a number of other interagency partnerships. They point to the reality that people with mental illness are served by many of our State agencies—education, health care, social services, housing/homelessness, disability/income support, criminal justice/probation and others. The collaborations extend beyond each single agency, involve others with a stake in the outcomes, and lead to solutions that exceed what any one participant may have seen as possible.

### **Collaboration among Mental Hygiene Agencies**

The “People First” forums of 2007 continue to serve as a firm foundation for essential work taking place among the three Mental Hygiene agencies—OMH, OASAS, and OMRDD—under the auspices of the Inter-Office Coordinating Council and its Chair, OASAS Commissioner Carpenter-Palumbo. Under its umbrella, the Mental Hygiene County Planning Committee, in collaboration with the Conference of Local Mental Hygiene Directors, is promoting a more efficient and uniform local services planning process that links more closely local governmental and State planning.

The Most Integrated Setting Coordinating Council (MISCC) continues to work dili-

Collaboration is a process through which people who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible.

— *Building a Collaborative Workplace*  
*www.anecdote.com*

gently under Commissioner Ritter’s leadership to better address the housing, employment, and transportation needs of New Yorkers with disabilities. In collaboration with the MISCC Employment Committee, the Burton Blatt Institute at Syracuse University and the Employment and Disability Institute at Cornell University, New York State has been awarded over two years a \$12 million Medicaid Infrastructure Grant. The award, made available through OMH, is helping to remove obstacles and develop pathways to employment for all New Yorkers with disabilities. Called “New York Makes Work Pay,” the initiative intends to improve the rate of employment dramatically for these individuals.

### **Criminal Justice Collaborations**

Studies find that contact with the criminal justice system for people with serious mental illness is a burden on the law enforcement, court, and corrections systems. Our goal is to ensure quality care for persons who are incarcerated and have serious mental illness, while improving our community response to peo-

ple with mental illness who have contact with the criminal justice system—across the continuum from first contact with law enforcement to Court programs to improving the safe re-entry of inmates with a mental illness to communities. All of these efforts involve collaboration and a focus on connecting offenders with mental illness to supervised treatment.

Through collaboration with DOCS, OMH offers a full complement of mental health services to State prison inmates. OMH and DOCS have worked together to create additional specialized services for inmates with disciplinary confinement sanctions and provide a host of other treatment modalities that meet inmates’ individualized needs. On December 15 of last year, New York opened its first-in-the-nation 100-bed Residential Mental Health Unit (RMHU) at the Marcy Correctional Facility. It serves inmates in this difficult-to-treat population using various treatment interventions and strategies that have demonstrated effectiveness. The RMHU, the hallmark of the 2007 court-approved private settlement agreement the State reached with Disability Advocates Inc., is the most comprehensive mental health prison treatment program developed in the United States in the past 20 years. Of note, a second Unit is planned at Five Points Correctional Facility in the future.

Collaborations with other State agencies are also ensuring compliance with the Sex Offender Management and Treatment Act (SOMTA), which targets those sex offenders with mental abnormality that predisposes them to commit sex offenses, and those hav-

ing serious difficulty in controlling their conduct. Under the law, two options exist: individuals may be placed by a judge on strict and intensive supervision and treatment (SIST), living in the community under close supervision by the Division of Parole; or, if they are more dangerous, they may be ordered by a judge to be civilly confined and provided treatment in distinct sex offender facilities within OMH psychiatric hospitals. The population receiving intensive OMH services under civil commitment has continued to increase; growth up to 230 individuals is anticipated in the coming year and transportation and security costs will be contained by encouraging courts to rely on video-conferencing for certain judicial proceedings.

Finally, OMH remains committed to collaborations that divert adults and youth from correctional systems wherever appropriate. These collaborations span from training initiatives with local law enforcement to strengthening law enforcement responses to community mental health crises. They include collaborations with courts to reduce the frequency of contact with the criminal justice system through court-provided resources that improve social functioning and link individuals to employment, housing, treatment, and support services. And, collaborations involve technical support and expertise aimed at improving the social and emotional well-being and mental health of New York's most vulnerable children and youth.

## Recovery, Resiliency and Transformation in Action

In mental health systems across the nation, including New York's, three major mental health concepts—recovery, resiliency, and transformation—are the bedrock for reform of mental health services. For OMH, these concepts share two fundamental truths: first, each reflects a journey rather than a destination. Increasingly, this is the message of recovery—not remission or a miracle cure—but the process of taking on life's challenges and living a good life despite illness and loss. Second, each of these concepts recognizes that change is ultimately the responsibility of the individuals who must achieve something different. Treatments that are theoretically the best but not accepted by an individual are unlikely to be effective.

Mindful that change is a “bottom-up” as much as a “top-down” process, OMH is adjusting processes that lead to the best outcomes for the adults, children and families it serves. The assessment, planning, delivery and evaluation of mental health services in New York State recognize very challenging fiscal times, a mature mental health system, no new resources, tremendous stressors, and great diversity in local needs. We look for feasible effective actions and intentions to promote mental health at every level of the system of care and to build empowering services from the ground up. We take approaches that strengthen our capacity to enable people to direct their own recovery

from illness. We are constantly looking for simple, yet powerful ways we all can support recovery, resiliency and healthy growth. Some examples include:

- ◆ *New York Makes Work Pay*  
We are working on solutions to address the State's estimated 70 percent unemployment rate among working-age people with disabilities (85 percent for people with serious psychiatric disabilities). As noted previously, the project is being advanced in collaboration with employment and disability experts at Cornell and Syracuse Universities. Early successes include training more than 3,000 individuals to assist consumers to obtain and manage benefits so that they do not create a disincentive to working, and increasing use of the State Medicaid Buy-In Program (under which people with disabilities can go back to work but keep their health insurance) by more than 20 percent.
- ◆ *PROS*  
This best-practice modality assists individuals in recovering from the disabling effects of mental illness through coordinated and customized rehabilitation, treatment and sup-



port services. OMH has made regulatory changes intended to diminish programmatic barriers to PROS adoption, including simplifying registration, documentation requirements, and billing requirements for clinical practice. PROS has more than doubled the number of licensed programs, from 13 at the end of 2007 to 28 today. Moreover, 42 agencies have confirmed their interest in seeking PROS licensure.

◆ *Peer Recovery and Technical Assistance and Recovery Centers*

Through targeted investments in last year's Budget, modest federal grant funding and active stakeholder participation, OMH is promoting peer leadership and creating a best practices model for peer recovery centers. In the current year, we will begin assisting local peer programs to make the journey toward becoming full-fledged recovery centers.

◆ *OMH Statewide Comprehensive "5.07" Plan*

This year's annual Plan was developed to rest on the stories and experiences of individuals who are or have been engaged in services, their friends and family members. While each person's background and experiences are uniquely their own, the insights and experiences are inspiring, give us glimpses into recovery, and serve as a strong source of motivation for change. The voices of these individuals give rise to our shared humanity and our collective desire to support them and other New Yorkers as they continue on their journeys toward improved health and well-being. They also underscore the meaning of re-

Recovery gives us a whole new way of looking at the world. Instead of focusing on symptom relief or functional disabilities, we focus on rebuilding lives.

— *Dr. Mark Ragins*  
*Medical Director, The Village,*  
*Long Beach, California*

covery to individuals as a process by which they rebuild their lives while managing their illnesses and symptoms.

## Budgeting and Management in a Fiscal Crisis

Even as we recognize the vital nature of good mental health, we realize the serious state of the economy and the severe economic downturn that took hold last year. Governor Paterson has responded by taking bold steps to weather the rough times, to keep annual spending in line with reasonable revenue assumptions, and to achieve structural balance in the Budget. Current economic conditions

Today is not a day to look back. It is a day to turn crisis into opportunity, to reclaim our government and recommit ourselves to doing better for the people of New York.

— *Governor David A. Paterson*  
*2010 State of the State*

make it imperative that we not only hold down mental health spending while preserving and sustaining clinical safety and quality, but also continue the restructuring of services to achieve better value at a lower relative cost.

New York State has made substantial steps to control mental health spending and has additionally shifted away from a reliance on State general funds. From 2001 to 2007, the increase in OMH expenditures was almost 40 percent below the average spending increase for state mental health agencies. The shift toward Medicaid highlights the importance of rationalizing the relationship between Medicaid and mental health. Moreover, it reminds us that reductions in relative general fund support for mental health care may have reached their limit.

### **Multi-Year Savings Actions and 2010-2011 Executive Budget Recommendation**

Taking inflation into account, funding for mental health has remained essentially flat for a decade. In response to the worsening budget crisis, spending for mental health care in New York State was reduced through two rounds of budget actions in 2008—the first in the Enacted Budget and the second at Governor Paterson's direction and in the special legislative session in August of 2008. OMH identified more than \$100 million in savings actions.

The 2009-2010 Enacted Budget reflected a commitment to sustain core programs while staying focused on an agenda of recovery for individuals with mental illness. We continued

to restructure our large, complex system of care by increasing access to acute inpatient care, while repurposing unneeded capacity; increasing the focus of State-operated community services; reorienting programs toward recovery and resiliency, while reducing the growth in spending through efficiencies; and continuing to defer new spending commitments when feasible. During 2009–2010, further savings efforts were required to respond to the ever-increasing gap in the State’s financial plan. Through two more rounds of cuts—the first focused on reductions in spending in State operations and the second on the Deficit Reduction Plan (DRP) passed in November by the Legislature—OMH generated savings totaling \$87 million.

This year Governor Paterson proposes a 2010–2011 Executive Budget for the State that makes significant spending reductions to eliminate a \$7.4 billion deficit and institutes key reforms to put New York on the road to

economic and fiscal recovery. The Executive Budget for OMH balances the competing challenges of achieving savings while ensuring that essential mental health obligations continue to be met.

### **Aid-to-Localities Budget Recommendation**

Aid-to-Localities funding in the 2010–2011 Executive Budget continues to be targeted toward improving access to community supports and services, fostering interagency partnerships, and orienting services to be consumer and family driven. The Proposed Budget Recommendation aims to lower the rate of growth in spending by promoting efficiencies and restructuring funding models, converting under-utilized resources into sustainable cost-effective alternatives, and continuing a multi-year delay of prior-year initiatives until they are fiscally feasible.

Major themes guiding the Recommendation include:

- ◆ *Continuing ambulatory restructuring*  
Expands access to outpatient clinic treatment, and supports implementation of the APG rate methodology to rationalize reimbursement and ensure consistency with federal requirements
- ◆ *Restructuring existing services for the implementation of The Children’s Plan*  
Redesigns base resources for Clinic-Plus services to improve clinical and operational functioning of children’s clinic treatment, and redirects under-utilized resources for residential units to expand community capacity (e.g., Home and Community-Based Waiver services) to serve children and their families at home

#### ***Aid-to-Localities Budget Recommendations***

	<b>GF/Mental Hygiene Program Fund</b>	<b>Other Funds</b>	<b>Total Operating</b>	<b>Capital Fund</b>
2009/10 Available	\$1,085,344,000	\$52,430,000	\$1,137,774,000	\$61,000,000
2010/11 Executive Recommendation	\$1,180,730,000	\$52,680,000	\$1,233,410,000	\$61,000,000
<b>CHANGE:</b>	<b>\$95,386,000</b>	<b>\$250,000</b>	<b>\$95,636,000</b>	<b>\$0</b>

*Note: These highlights reflect Financial Plan cash spending projections for OMH Aid to Localities funding in the 2010/11 Executive Budget.*

- ◆ *Continuing commitments to expand capacity for peer support and improve employment opportunities for individuals with disabilities*  
Annualizes funding to support Peer Recovery and the Technical Assistance and Resource Center development, and includes an additional \$6 million in federal grant funding awarded to New York for continuation of the New York Makes Work Pay program

- ◆ *Proposing a multi-year remedial plan in response to a federal court ruling in the Adult Home litigation*

Includes funding to begin assessments and expand supported housing capacity for individuals leaving adult homes under the proposed remedial plan

Building on \$57.9 million in savings as part of the 2009-2010 DRP, OMH proposes various savings actions during the 2010-2011 Fiscal Year totaling \$21.4 million as follows:

- ◆ Maximizing recoveries of State Aid funding and COPs to become current with past-due reconciliations
- ◆ Recovering exempt income from community residences and family-based treatment programs consistent with contract agreements for retroactive time periods
- ◆ Carving out pharmaceutical purchasing from the Medicaid methodology for children and youth residential treatment facilities to improve access to care for high-need children and generate Medicaid rebates savings for fee-for-service billing
- ◆ Annualizing 2009-2010 cost savings resulting from the DRP
- ◆ Eliminating enhanced funding for the Unified Services program in five counties con-

sistent with the 2009-2010 Enacted Budget

- ◆ Continuing to support a multi-year restructuring of prior-year initiatives to defer costs for new commitments until fiscally feasible (community residential and family-based treatment model enhancement, family care reimbursement upgrades, the addition of family support services to Clinic-Plus, establishment of managed care demonstration programs, and care management for co-occurring mental health and substance abuse disorders)

As the 2010-2011 Executive Budget recognizes significant savings, it also includes funds to annualize prior-year commitments and underscores the Governor's support for essential community-based mental health services. The Proposed Budget includes funds for the following:

- ◆ Reinvestment of funds resulting from residential development delays to support a proposed multi-year remedial plan to provide supported housing for individuals currently in adult homes. One million dollars will be made available to begin assessments for adult home residents, with funding of \$20 million annually in five years, for 1,000 additional supported housing units, education, skills development, and ongoing assessment of remaining adult home residents
- ◆ Continued development of priority and/or shovel-ready residential initiatives (e.g., New York/New York III agreement, supported housing units) and annualizing units opened in the current year and the more than 1,300 new units scheduled to open by the end of 2010-2011. At the same time, the Budget Recommendation

maintains the 2009-2010 freeze on new construction of approximately 1,600 units. During the moratorium, we will continue to explore restructuring capital commitments into lower-cost, mixed-use housing and rental units.

- ◆ Annualization of funding for prior-year initiatives including ambulatory care restructuring, implementation of Children's Plan recommendations, operation of the peer-support resource center, model adjustments for community residences and family-based treatment programs, enhancement for family care reimbursement, the addition of family support services in Clinic-Plus, and managed care demonstration projects
- ◆ Funding to annualize programs already in development by supporting conversions to recovery-oriented PROS
- ◆ Annualization of funding for program conversions (such as the restoration of State Aid for hospitals exceeding disproportionate share caps) partially offset by cost savings measures initiated in the 2009-2010 Enacted Budget
- ◆ The addition of a new \$6 million appropriation (federal funds) for the New York Makes Work Pay employment program, bringing the total funding level for New York to \$12 million
- ◆ Capital disbursements for community facilities, for ongoing maintenance and continued development of units already in design or construction, as well as priority housing initiatives excluded from the freeze

**State Operations Budget Recommendation**

The State Operations Executive Budget provides funds for OMH’s network of psychiatric health care settings. OMH psychiatric centers are required to meet national accreditation standards set by The Joint Commission and the Centers for Medicare and Medicaid Services. These standards establish that hospitals meet conditions of participation and coverage for Medicare and Medicaid, and protect the health and safety of beneficiaries. Maintaining accreditation is critical for sustaining approximately \$1.3 billion in revenue streams to the State.

While significant savings have been identified in the budget development process, the net growth in spending must be used to maintain safe, quality care for the vulnerable population served by OMH. The growth supports negotiated salary increases, related general State charges (e.g., pension costs), and restores funds for energy, pharmacy and medical expenses.

Added to the \$29.2 million of savings in 2009–2010, savings proposed in 2010–2011 total \$63.9 million (including related fringe and indirect savings). The 2010–2011 Executive Budget annualizes the savings measures initiated during the 2009–2010 Fiscal Year as part of the Voluntary Severance Program (VSP), which resulted in a reduction of 290 full-time equivalent (FTE) positions. The Proposed Budget also continues non-personal service savings measures taken through agency operating efficiencies as part of the 2009–2010 DRP.

Specifically, proposed savings during the 2010–2011 Fiscal Year come from:

- ◆ *Ward efficiencies*  
Up to 250 adult inpatient beds are authorized for reduction or replacement through conversion to TPPs, which enables individuals to move into community care.
- ◆ *Operating efficiencies*  
Examples include the conversion of certain

information technology contracts to State jobs, overtime savings, reduced salary enhancements for selected clinical titles, teleconferencing of certain SOMTA judicial proceedings, and OMH’s share of proposed statewide collective bargaining savings.

Consistent with OMH’s requirement to maintain core-mission operations, the Proposed Budget provides funds to annualize prior year commitments and savings initiatives as follows:

- ◆ Prior-year initiatives adjustments related to the annualization of 2009–2010 adult inpatient restructuring; SOMTA expansion to support projected census growth to 230 individuals; annualization of the VSP savings; and continuation of other hospital programs
- ◆ \$160 million in funding for base operations, including negotiated salary increases, salary increases for State employees not yet at job rate, fringe benefits and indirect costs, and restored energy, pharmacy and medical expenses

**State Operations Budget Recommendations**

	<b>Mental Hygiene Program/PIA Funds</b>	<b>MH/PIA Fringe &amp; Indirect Funds</b>	<b>Other Funds</b>	<b>Total Operating</b>	<b>Capital Funds</b>
2009/10 Available	\$1,400,533,000	\$516,311,000	\$7,025,000	\$1,923,869,000	\$250,751,000
2010/11 Recommendation	\$1,449,436,000	\$580,927,000	\$7,325,000	\$2,037,688,000	\$268,464,000
<b>Change</b>	<b>\$48,903,000</b>	<b>\$64,616,000</b>	<b>\$300,000</b>	<b>\$113,819,000</b>	<b>\$17,713,000</b>

*Note: These highlights reflect Financial Plan cash spending projections for OMH State Operations funding in the 2010/11 Executive Budget*

- ◆ Appropriations to recognize grant funding received by certain New York City area psychiatric centers participating in New York City's Healthcare Emergency Preparedness Program
- ◆ All Funds support an estimated 16,169 FTEs at the end of Fiscal Year 2010–2011, reflecting a net budgeted reduction of 128 authorized FTEs from March 31, 2010
- ◆ Ongoing support for 3,380 adult inpatient beds, 538 children and youth inpatient beds, 715 forensic inpatient beds, and a projected SOMTA census of 230; in comparison, in 2007–2008 OMH supported 4,030 adult inpatient beds, 526 children and youth inpatient beds, 695 forensic inpatient beds, and a SOMTA census of 123 individuals.
- ◆ Capital disbursements targeted toward

support of building preservation, design, and construction, health and safety, accreditation, energy conservation and environmental protection

## Conclusion

To meet the State's major mental health obligations, Governor Paterson has proposed a Budget for 2010–2011 that sustains essential mental health services at a time when many New Yorkers are severely challenged by the current economic climate. This Budget preserves necessary clinical safety and quality while balancing numerous savings actions

with support for prior-year commitments. The Budget continues to defer multi-year obligations, freeze residential development and constrain spending, while preserving programs that meet the basic mental health obligations of New Yorkers with the most serious mental disorders. It also sustains urgently needed reforms that will increase quality, accountability and efficiency.

We look forward to the discussions and deliberations needed to advance this Budget and help sustain the progress we have made to date. We are committed to move forward with you in shaping a system of care premised upon good mental health and improved well-being for New York's most vulnerable citizens.