



Testimony of

Heather R. Mermel, Director of City and Federal Policy and Advocacy of
The Coalition of Behavioral Health Agencies, Inc.

At the Hearing on the
Oversight of Kendra's Law

The Committee on Mental Health, Mental Retardation,
Alcoholism, Drug Abuse and Disability Services
Hon. G. Oliver Koppell, Chair

November 19, 2010

Good afternoon Chairman Koppell and distinguished members of the Committee. I thank you for affording us the opportunity to testify before you today on the oversight of Kendra's Law. My name is Heather Mermel, and I am the Director of City and Federal Policy and Advocacy at The Coalition of Behavioral Health Agencies (The Coalition).

Enacting Kendra's Law

Kendra's Law was enacted in 1999 to establish a system of court-ordered outpatient mental health treatment for certain individuals with psychiatric disabilities. Its purpose is to ensure that individuals with mental illness and a history of hospitalizations, considered to be a danger to themselves or others, participate in community-based outpatient treatment. In 2005, Kendra's Law was extended until June 30, 2010, to allow for further study of the efficacy of the Assisted Outpatient Treatment (AOT) program created under Kendra's Law. When the Law was set to expire again, The Coalition supported another extension of Kendra's Law for an additional 5 years (until June 30, 2015), rather than a proposal to make it permanent. We did so in order to allow New York State to continue its analysis of the long term effectiveness of Assisted Outpatient Treatment.

The 2005 reauthorization of Kendra's Law required an independent evaluation of the implementation and effectiveness of AOT. In the 2009 study conducted by Duke University titled "New York State Assisted Outpatient Treatment Program Evaluation," the report failed to prove that court-ordered treatment was more effective and beneficial than participation in voluntary treatment. The report stated that only a limited amount of data was available, and that the long term effects of Kendra's Law are inconclusive. In supporting the extension of

Kendra's Law, The Coalition urged the State to investigate further the efficacy of voluntary versus court ordered treatment.

Implementation Issues

The effectiveness or lack thereof, of Kendra's Law may very well have its roots in the original implementation of the program. When originally enacted, the New York State Budget for FY 2000-01 included funding for its implementation. Even with the funds, programs reported a reduction in access to services for non AOT recipients. The statute requires programs to prioritize services for this high-need population with the consequence of shifting resources away from clients who seek treatment on their own. Additional mandates of the statute include onerous reporting and documentation of services, resulting in a costly program.

The AOT program in New York City is overseen by the Clinical Director for the Department of Health and Mental Hygiene (DOHMH), and administered by the Health and Hospitals Corporation (HHC). AOT recipients are referred to community-based programs through the City's Single Point of Access (SPOA). Although the SPOA referral process is an objective one, insuring that AOT clients are appropriately referred, some providers report a disproportionately higher number of individuals assigned to their programs that are not Medicaid eligible or have no insurance. Even if a consumer has managed care, reimbursement rates are significantly lower than Medicaid. Providers also find it extremely difficult to obtain reimbursement from commercial insurance companies for services provided to AOT recipients. Programs that serve a high proportion of AOT clients report a significantly higher unit rate of service for those recipients. As a result, some agencies have closed programs (including ACT teams) because their Boards could no longer allow these programs to operate in the red.

Program Services

AOT recipients may receive a variety of outpatient services including residential programs. All AOT recipients **must be** enrolled in a case management or ACT team. For each individual referred, providers are required by the Law to meet increased compliance monitoring standards and submit frequent treatment status reports to the local AOT Program Directors and when necessary, to the courts. Because each AOT client is additionally assigned to an HHC staff person, providers are also required to speak with the assigned HHC representative on a regular basis. Programs must also conduct outreach and engagement services, monitor or coordinate blood work (to insure that the recipient is complying with their medication regimen and not abusing other substances), offer more frequent clinical contact and as already noted comply with more rigorous documentation requirements. Staff report having to dedicate several hours per week to complete all of the necessary paperwork, making it more difficult to provide direct services to other clients enrolled in their programs. Without new dollars to continually support the AOT system providers are overburdened with meeting the requirements of Kendra's Law and the overall access to mental health services is limited.

Conclusion

The lack of financial resources may very well impede the effectiveness of Kendra's Law. If the City and State continue to prioritize the AOT program, dollars must be found to support agencies that provide direct services to this population. In addition, the City and State must streamline and simplify the administrative, programmatic and documentation requirements of Kendra's Law. We thank you for your time today, and are available to answer any questions you may have.

About The Coalition

The Coalition is the umbrella nonprofit, (501)(c)(3), association and public policy advocacy organization of New York's behavioral health providers, representing over 100 non-profit behavioral health agencies. Taken together, these agencies serve more than 350,000 adults and children and deliver the entire continuum of behavioral health care in every neighborhood of a diverse New York City, Westchester County and surrounding areas.

Founded in 1972, the mission of the Coalition is to coordinate the efforts of government and the private sector toward efficient delivery of quality behavioral health services to children, adults and families. The Coalition promotes policies and practices that support the development and provision of community based housing, treatment, rehabilitation, and support services to all people with mental illness and addictions disorders. Our members serve a diverse group of recipients, including the fragile elderly, people who are homeless, those who struggle with AIDS and other co-morbid health conditions, violence and other special needs. Coalition members help people with mental illness and addiction disorders to recover and lead productive lives in their communities.

The Coalition provides quality learning opportunities, technical assistance and training to staff and leadership of its member agencies and to the professional community on important issues related to rehabilitation and recovery, organizational development, best practices, quality of care, billing and regulations/contract compliance, technology and finance.