



Testimony of
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On the 2004-2008 New York State Office of Mental Health
Statewide Comprehensive Plan for Mental Health Services

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Good morning. My name is Phillip Saperia, and I am the Executive Director of the Coalition of Voluntary Mental Health Agencies. The Coalition is the umbrella advocacy organization of New York's mental health community, representing over 100 non-profit community based mental health agencies. Our members constitute a broad cross section of outpatient service delivery agencies in New York City – of every size and service modality – serving more than 300,000 individuals in the five boroughs of New York City and its environs.

The Coalition would like to thank the Office of Mental Health for initiating formal briefings across the State concerning the 5.07 Plan for 2004-2008. These briefings allow for respectful interchange between OMH and other stakeholders about how the Plan is developed and suggestions for making the document more useful in the future. These briefings should serve as the first step of a long-awaited mechanism for public input between OMH and other stakeholders that is so critical if we are to more effectively address the needs of mental health consumers across the State.

I would now like to address the Plan itself. In analyzing the narrative and the accompanying data and charts, it becomes clear that the Plan addresses in varying levels of detail the range of services currently in existence for mental health consumers. Unfortunately, the Plan does not highlight unmet need. The decision by the Executive to issue the Plan simultaneously with the Governor's Executive Budget means that the budget development may be ill informed by

objective needs assessment and the planning process. The Coalition strongly believes that the budget might more accurately reflect and definitively address the needs and concerns raised in the Plan were it released in October, in compliance with the current law. While we would like the Plan to discuss the current array of services, it must also show the unmet need in the community and perhaps, point the way to addressing that need.

The key component of any Plan that seeks to firmly address the issue of “unmet need” is reliable data, particularly relating to populations, geographical considerations, cultural issues, safety and costs. Allow me to give just a few examples where the community mental health sector would greatly benefit from the collection of, and subsequent attention to, the kind of data that illustrates what our providers and their consumers face each day.

Housing for mental health consumers is a matter of concern throughout the State, but perhaps nowhere more so than here in New York City. Vast numbers of mental health consumers currently seek refuge in the City’s array of homeless shelters and drop-in centers, while others reside in the notoriously dangerous adult homes that have been the subject of much scrutiny in recent years. Still others live with aging relatives, constantly flirting with eviction and homelessness. For the purposes of today hearing, however, we would like to focus on the Supported Housing model and the inadequacy of its funding by the State.

For several years now, a large contingent of advocates and providers (including the Coalition) has pointed to the sharp discrepancy between the contract rates paid for Supported Housing and the actual cost of renting an apartment and providing services. In New York City, where rents commonly approach and even exceed \$1,000/month, providers are finding it nearly impossible to provide adequate housing and meaningful services for the contracted rate of \$11,300/year. In fact, a growing chorus of providers tells us that unless an immediate rate adjustment is made to the Supported Housing program, they will be forced to turn back their unaffordable leases, effectively putting tenants onto the streets and into the homeless shelters. With over 38,000 men, women and children currently living in the New York City shelter system each night, the loss of even one Supported Housing program would only compound that misery for New Yorkers living with psychiatric disorders.

In short, what is needed is the collection and organization of data that would accurately reveal the discrepancies in each geographical region between the contract rates and actual costs for the Supported Housing program, as well as the need for additional housing units based on existing data for homelessness in each region. Instead, readers of the Plan learn only that the level of community-based housing has increased by 60% since 1995, and that the number of units, including those in development, will total 31,000 by the end of Fiscal 2004-2005. And while the Coalition is gratified that the Governor recognizes the importance of creating more housing, including the development

of 600 additional units of Supported Housing in his 2004-2005 Executive Budget, there needs to be a similar commitment to funding these units to reflect actual costs, particularly in New York City where rental costs have skyrocketed over the past several years.

It is essential that the Plan include the wealth of information collected by LGUs and information shared by local stakeholders in order to compare regional differences and identify differential needs. New York City in particular has very unique needs and demands, owing in part to the sheer number and diversity of consumers (and providers). In order for the Plan to more accurately reflect this diversity, OMH should collect and analyze current data on the large number of immigrants, the uninsured, and the working poor – in short, those individuals in New York City most likely to be **ineligible for Medicaid**. This fact is of great concern to The Coalition since more and more programming will come under Medicaid's domain. There is no mention in the Plan of the implications of such a large shift to Medicaid. The Plan does acknowledge the role of OMH's Multicultural Advisory Committee in helping to shape the agency's mental health care for New Yorkers from diverse ethnic backgrounds, but there is no mention of how the particular needs of immigrant consumers fit into the State's plan for PROS, for example. Nor is there mention of the implications of such a large-scale shift to a Medicaid-funded system at a time when federal caps on Medicaid continue to be discussed in Washington, D.C. and when local governments are groaning under its burden. Absent this attention to the particular needs of each

region, the Plan lacks complete information about the diverse universe of consumers and the corresponding struggle of providers to assist them.

We are concerned that the Plan does not appear to address the particular needs of geriatric mental health consumers. This population will soon demand a more sizeable portion of OMH's resources, yet there is no mention of their issues or the State's arrangement to provide for them in the Plan. The emergence of baby boomers into this population category will increase the numbers of aged in proportion to the population and make the need for services even more critical.

The Coalition applauds SOMH's efforts to introduce evidence-based practices. However, we are concerned that the State continues to promote evidence-based practices without regard to geographic location. Very simply, the research, population and geographical areas upon which the evidence is based does not account for factors of racial, ethnic and cultural diversity that typify the New York City populations served by the City's providers. It is also questionable whether there are adequate resources within the immediate New York City environs to provide the essential training and ongoing clinical supervision to providers that will be necessary to implement EBPS consistently and effectively. In fact, New York City's providers are engaged in programs and service delivery models that may be considered "promising practices." They serve many special and diverse populations under particular urban circumstances. These should be

considered for testing and development since they may rise to the level of “Evidence- based.”

We do recognize, and applaud, OMH’s desire to shift resources away from costly and underutilized State-run psychiatric institutions and divert them instead to community-based services. The Coalition, together with several other advocacy organizations throughout the State, publicly supported the notion of a bi-partisan blue-ribbon commission to study, and ultimately act on, this issue. And while it doesn’t appear likely that this commission will take shape in the coming fiscal year, we continue to support the State’s efforts to engage in this form of long-term planning on how best to re-allocate its psychiatric resources.

We would be remiss if we failed to mention that the Community Reinvestment Act, which re-allocated funding from underutilized State psychiatric beds into the community mental health sector, was a shining example of the State’s pursuit of long-term planning. As beds were closed and funding made available, the State worked with the local stakeholders in deciding how best to allocate these resources.

We also applaud OMH’s recognition of suicide prevention as a major mental health issue, and commend Commissioner Carpinello for her recent efforts to draw public attention to this effort. Her recent promotion of the Suicide Prevention Education Awareness Kit (SPEAK) demonstrates OMH’s effort to

recognize a growing mental health issue, identify the populations most likely to be affected, and allocate the resources necessary to overcome this crisis.

In sum, the state planning process has been broken for many years now. We applaud efforts to re-invigorate it with this new planning document, briefings and hearings. An adequate planning process – one we believe is vital to a dynamic mental health sector such as ours – ought to rely on publicly available data that is produced in a timely fashion. It ought to solicit, organize and analyze data that consider financial modeling and reflect county needs. It ought to be a forward-looking document that identifies existing service gaps. And, and it ought to include real efforts to address the future needs of the system.

Ultimately, for the Plan to be effective, an effort must be made to identify, collect, and analyze data to address the needs, both current and future, of mental health consumers and the providers who serve them. This must be a transparent process, and it must be done with an eye towards the unique characteristics of each geographical area. The planning ought to be done throughout the course of the year, and should be viewed as a “bottom-up” process and one that facilitates the collaboration between LGUS’s, stakeholders and OMH. In short, the 5.07 Plan needs to better conform to the letter and the spirit of the law.

Thank you.