



Testimony of David Bergman
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before the
Mental Health Services Council

On the state planning process for mental health services

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Good afternoon. My name is David Bergman. I am a Senior Policy Associate with 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 clients in the five boroughs of New York City and its environs.

Planning functions are among those most elemental to the adequate performance of social services in the public sphere. This is particularly so as it relates to healthcare and, in our case, mental health care. The process for developing that plan—as well as what that a plan ought to contain—has been largely absent from the statutorily required §5.07 plans submitted by the State Office of Mental Health over the last few years. A major shortcoming of the '03-'07 State Plan was that it merely reported on the services that were already available or in the pipeline. This kind of tautological planning will get the system nowhere. We are pleased that this effort is being addressed by this hearing, and commend you for your attention to this matter.

We have testified before about the five essential components that must be contained in a five-year plan. These include descriptions of:

1. existing services;
2. those currently being served;
3. the need for services not being met in the current system;
4. those that will need services in the future; and
5. a plan for developing resources to serve unmet need.

However, in order to develop a plan which addresses these issues, accurate and timely data must be available. Data is already available from such sources as the patient characteristic surveys, Medicaid usage data, volume reports, housing supply, and others. But this is often not incorporated into the plan. Looking more closely at this information will yield such important information as who is using the services and their intensity of use. Cross-referencing this information with program capacities would be invaluable to the development of a genuine plan.

A plan would also, ideally, include data on costs—especially when compared to other measures. It has been a sadly ignored fact that in residential programs like Supported Housing, the cost of providing the services has sharply outstripped the contract rates. Failure to analyze or account for this most basic of phenomena undermines the mental health sector by presenting a false sense of a stable sector. We have reported elsewhere that the turnover in community mental health agencies is far too high. A stable system with an adequately paid workforce will provide continuity to consumers and propel them along a path to rehabilitation and recovery. This will happen more efficiently and more effectively—i.e. less expensively—if turnover is curtailed.

There are clearly difficulties in developing a plan which forecasts need and identifies those not currently using the system. There are likely no perfect sources which will yield perfect data. Nonetheless, the lack of perfect data should not stand in the way of the effective use of proximate data. This will require collection of information on two different levels: through collection of system wide data, and through public comment.

At the state-wide level, it would be relatively easy to collect information on waiting lists, and the time spent waiting to access services. Additionally, the discharge data from hospitals and the forensic system—when compared to the services accessed and available in the community—could yield valuable information about issues. Although neither of these sources are in any sense perfect, they will begin to paint a picture of any needs for additional capacity—in clinic services, in housing, and in targeted services for those leaving prisons and jails, among others.

Of course, the other major element that should be incorporated in a state planning process is an opportunity for smaller level stakeholders to impact the plan. This can and should take two forms: stakeholders should be given the opportunity to make suggestions directly to the state through a state-wide hearing process, and county level directors should be able to identify county needs. This action could easily result in a new and important state initiatives to target, for example, co-occurring disorders, or those with forensic pasts. Efforts coordinated at the state-wide level can have an enormous impact on the efficacy of services as well as their coordination across disability strata. Further, it will allow counties to benchmark and track their own initiatives on a year to year basis.

Anecdotally, we believe that there are major gaps in existing services for people with mental illness. These include both the capacity and infrastructure of housing services—as evinced by the sharp rise in shelter usage, the unsolved problem of adult home residents with mental illness, and the on-going crisis of insufficient contract rates for Supported Housing.

In sum, the state planning process has been broken for many years now. We applaud efforts to re-invigorate it with this hearing and the others that

will follow. 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 further earmark sections that discuss financial modeling and county needs. It ought to be a forward looking document that identifies service gaps projects need. And, it ought to include real efforts to address the future needs of the system

Thank you.