



Testimony of

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At a New York City Council Oversight Hearing:

“Are Mentally Impaired Individuals in New York City Receiving
the Appropriate Services to Maintain Stability for Themselves and
to Safeguard the Health and Welfare within our Communities?”

The Committee on Mental Health, Mental Retardation,
Alcoholism, Drug Abuse and Disability Services

Hon. G. Oliver Koppell, Chair

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INTRODUCTION

Chairman Koppell, distinguished members of the Committees, thank you for inviting us to testify before you today on the topic of continuity of care for mental health consumers. My name is Michael Polenber, and I am the Director of Policy & Advocacy for the Coalition of Behavioral Health Agencies, the umbrella advocacy organization of New York's behavioral health community, representing over 100 non-profit community-based mental health and substance abuse agencies in New York City and surrounding areas. Our members constitute a broad cross section of service providers – all sizes from very small to very large; treatment and rehabilitation-oriented; outpatient and residential; focused on linguistically and culturally specific populations and on many special-needs – serving more than 300,000 individuals in the five boroughs of New York City and its environs.

The City Council's decision to hold this oversight hearing, prompted by the assault on two people by a psychiatrically disabled individual who had apparently stopped taking his medication, results in a government inquiry based on a gross lumping together of all people who have mental illness. It is a discriminatory premise, and it raises the specter of stigmatizing the millions of Americans living with mental illness who are our friends and family members, who work with us, live with us, and strive, as we all do, to achieve a better life for themselves and their loved ones. In fact, persons with mental illnesses are statistically far more likely to be the victims rather than the perpetrators of violent crime.

We would like to try and put today's hearing in context by reflecting on the state of the community-based, non-profit behavioral health sector here in New York. It is a sector rich in expertise and proficiency, in diversity and service modality. It is a sector that is charged with providing the full continuum of care to individuals and families struggling to overcome the debilitating effects of schizophrenia, bi-polar disorder, schizoaffective disorder and major depression, to name just a few. Many of those served also suffer from chronic illnesses like diabetes, heart disease and respiratory ailments. Still others need treatment for addictions to alcohol, opiates, cocaine and other substances.

At the same time, there are systemic shortfalls in program capacity as well as public and private financial support. Lengthy waiting lists for clinics and mental health housing appear so often as to be unremarkable. State and City reimbursement for mental health programs cover only a fraction of the overall cost of program operation. Federal cutbacks in Medicaid and pending State and City budget deficits leave almost no margin of error for providers and those who rely on them for care. And Medicaid is governed by strict regulations that in some instances inhibit the delivery of a more flexible system of care.

Finally, there is the gap between inpatient care and the outpatient community-based sector into which we fear far too many mental health consumers are falling. Whose responsibility is it to ensure continuity of care when an individual leaves a hospital psychiatric bed and returns to the community? How can we be sure that

consumers are directed to care that is culturally, linguistically and clinically appropriate for the particular needs of the individual? And how can we ensure that consumers and their family members play an active role in their recovery and have a say in how and where they receive treatment?

EXISTING SERVICE OPTIONS AND CURRENT NEED

The community mental health system has a full continuum of services and housing for New Yorkers with psychiatric disorders. Community-based Article 31 mental health clinics, often referred to as the “portal” to the mental health system, provide counseling and treatment to approximately 90,000 men, women and children each year, comprising almost 80% of New Yorkers who seek publicly-funded mental health care. Continuing Day Treatment Programs provide active treatment, including medication therapy and education, case management, symptom management, and health referrals, to more than 23,000 seriously and persistently mentally ill men and women throughout the State, while 3,660 young people utilize children’s day treatment programs. Assertive Community Treatment (ACT) teams deliver mobile psychiatric services and case management to over 4,800 mental health consumers in natural settings, such as their place of residence. Case management teams help connect thousands of consumers with benefits, housing and treatment. Over 28,000 consumers reside in housing licensed and/or contracted through the State Office of Mental Health (OMH), and over 3,500 more live in apartments funded through the City’s Division of Mental Hygiene.

And yet the need for these and other mental health services is much, much greater. Almost all of our clinic providers report long waiting lists of consumers in need of psychiatric counseling, treatment and medication management. And just as many of our providers report difficulty in being able to hire psychiatrists for their clinics, given the high costs associated with that field. It can be even more difficult to find culturally and linguistically-competent psychiatrists, which are in great demand in communities throughout the City. Roughly one-third of the 6,700 adult shelter residents and the vast majority of the more than 3,000 individuals who sleep each night on the streets and in our parks suffer from a mental illness. The historic agreement entered into by the City and State to create 9,000 units of supportive housing over the next 9 years will be enormously helpful in addressing this crisis, but will still fall short of the total number needed to end mass homelessness in New York. Hospitals, shelters, adult homes, forensic settings, foster care settings, street homeless outreach teams...all are competing each day to fill the same handful of vacant community-based mental health beds.

FUNDING

Furthermore, the funding that supports existing community-based mental health programs pales in comparison to the cost of operating these life-sustaining services. Medicaid reimburses providers roughly half of what it costs to deliver a single unit of clinic treatment to a mental health consumer, and even less if the individual has complex needs and co-morbid physical and/or addictive disorders. Despite modest increases to the base rates for the OMH supported housing program, providers continue to struggle to reign in inflationary costs, including rent and utilities, while receiving a

fixed reimbursement rate. Many programs, including continuing day treatment and psychosocial clubhouses, have not seen a base rate increase in over a decade.

Subsequently, providers are forced to cobble together funding from a myriad of public and private sources in order to support programs that are designed to help the most vulnerable, most service-needy consumers. There is no pool of dollars for community-based providers to address uncompensated care, which for consumers in a city like New York can be the rule, not the exception. Federal efforts to reduce Medicaid expenditures will have chilling implications for all health care providers, particularly those working in the community-based behavioral health field. And finally, both State and City officials are warning New Yorkers of multi-billion dollar budget deficits for the years ahead, dimming our hopes of much-needed fiscal relief.

Furthermore, providers must adhere to incredibly strict Medicaid regulations that govern the frequency of visits for mental health consumers. For instance, if a consumer has an appointment with a clinical therapist, who determines that a follow-up visit to the psychiatrist would be warranted, this second visit is not reimbursable under Medicaid regulations unless it happens on another day.

CONTINUITY OF CARE

One of the areas of most concern to the Coalition is the gap between the inpatient and outpatient systems of care. With some exceptions, there is no seamless transition between the hospital bed (particularly the general hospitals) and the Article 31 mental health clinic, the continuing day treatment program, or other outpatient setting.

Furthermore, there is no guarantee that the consumer will be referred to treatment staffed by clinicians who are culturally and linguistically competent, an issue of tremendous importance in a city as diverse as New York.

Nor is there a “step down” system of care designed to address the short-term needs of individuals in need of after-care following a brief hospitalization as a result of a psychotic episode. Not everyone needs the intensity of a continuing day treatment program, but would benefit from a short-term residential day program with on-site mental health and, if needed, substance abuse counseling.

The Coalition is currently working with our colleagues across the State on helping OMH recognize these and other gaps in care, and we will be more than happy to share our findings with you in the coming months.

RECOMMENDATIONS

Ensuring that consumers can access care as quickly as possible has always been a chief concern for the Coalition. We hope this hearing will help raise awareness on the City Council about not only what is currently being offered, but what more needs to be done. We trust that over the coming months and years, the Council will continue to work with the Coalition and our colleagues in the mental health community to:

- invest much-needed resources into programs throughout the city that provide compassionate and effective care to New Yorkers with serious and persistent mental illnesses;

- promote clinical practices that are shown to be the most effective in moving mental health consumers along a path of recovery and wellness;
- ensure a diversity of staff equipped to provide culturally and linguistically competent care to consumers; and
- fight the discriminatory stigmatization of mental health consumers at all costs and in all settings.

Thank you for your time today, and we are available to answer any questions you may have.