ACL

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TESTIMONY TO MHANYS

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Good Afternoon.

My name is Antonia Lasicki and I am the Executive Director of the Association for Community Living (ACL.) ACL represents over 125 not-for-profit community mental health agencies across the state that provide an array of mental health services to severely and persistently mentally ill adults. I'm here today to focus on the future but to also briefly explain some of the problems that face the *residential* service providers who serve over 20,000 consumers every day across the state, and to ask that MHANYS make residential issues a priority in the coming years.

Before I do that, however, I would like to commend MHANYS on its most recent report ***The Unfinished Promise of Willowbrook: Twenty-five years of Unnecessary Despair for New Yorkers Living with Mental Illnesses.***

It has long been our position that there is a fairly consistent number of citizens in New York State who have a severe and persistent psychiatric disability, who are functionally impaired, and who are poor, that should be a priority for the state. This priority must transcend political philosophy, and party politics, in much the same way that funding for people with mental retardation and developmental disabilities has transcended politics since The Willowbrook Decree.

The most recent scandals in adult homes where people with psychiatric disabilities live in squalor and fear for their emotional and physical safety, as well as the nursing home scandal involving unregulated, segregated nursing home units that lock away consumers without due process, and the latest articles in the Times Union about consumers in jail must lead to one conclusion: that housing for people with psychiatric disabilities must be made the highest priority for all advocates in the mental health community.

However there is one area that has received little attention in the last months as scandal after scandal broke: the existing mental health housing programs, funded and regulated by the State Office of Mental Health, that are in fiscal crisis.

Attached to your packet is a chart that shows the cumulative Consumer Price Index over the last 10 years, as well as the increases to programs funded by the Office of Mental Retardation and Developmental Disabilities, and programs funded by the State Office of Mental Health. As you can see from the chart, OMRDD waivered programs have increased by 50% over the last 10 years, while the CPI has increased by 35%, however, the OMH funded residential programs that were cut in 1995 will just come up to the 1995 level when they receive the 3% COLA promised in December 2002. Contrast this further

with the state workforce that have also enjoyed rising wages – approximately 40% over the last 10 years.

It is impossible for not-for-profit residential providers to continue to function in this way, and consumers are ultimately the ones who are hurt. We can no longer attract or retain qualified staff resulting in interruptions in care. Standards and base rates that were developed for our programs over 20 years ago are too low to adequately serve the complex needs of today's consumers. As you can see there are hundreds of medications, as well as complex medical conditions and behavioral issues to manage. Our annual staff turnover rates are at 50% resulting in "burn-out" among our middle managers, and our administration and overhead share has gone as low as it can go. In the short term, we ask MHANYS to make stabilizing the community based residential system of care one of its highest priorities in the coming years, and that it support the following minimal needs:

- The licensed Community Residence program needs an immediate one-time increase to its Medicaid rate.

- The legislature passed Kendra's Law but provided no increased funding for providers. Enhanced service packages should be created immediately for those residences that serve a disproportionate share of "high risk, high need" consumers. Unless these resources are forthcoming, residences should be exempt from Kendra's Law placements, and "high risk, high need" obligations.

- Supported Housing stipends need to be sufficient, and based on cost. They need to cover rents, staff transportation, 1:15 staff ratio, office, telephone and an administrative share. Reinvestment beds should keep up with increases in state funded beds. A mechanism to trend the program stipends must be developed so that the rental portion of the Supported Housing program keeps up with actual rents.

- Single point of entry systems in counties must be created with provider input, and must not compromise an agency's ultimate authority over admission decisions.

However, even if the state gave community based programs all that they need, the long-term systemic funding problems remain. Realistically, the state cannot support both a substantial state institutional system as well as an adequate community based system. Given that there are only 4500 patients left in state institutions, and that there are over 20,000 beds in the community with a disproportionate share of the dollars going to the hospitals, the entire mental health system is clearly in need of an overhaul and a long-term plan. With today's medical technology, and recovery based rehabilitation practices, there is a need for only a few regionally based state psychiatric facilities as long as there is an adequate and localized community based system to take the place of the institutions. There is a role for public employees to play in any plan that is developed, however, any long-term program plan must be in keeping with a rehabilitation and recovery philosophy, and must be developed in the most-integrated settings in keeping with the Americans with Disabilities Act as interpreted by the Supreme Court in Olmstead. In addition, any plan must resolve the long-standing and growing disparity in wages between the public and private sectors.

In the early days of community based residential program development, wages in the not-for-private sector were approximately 80% what they were in state facilities, with

corresponding disparities in benefits. We could live with that. After all, tax-free status is granted to encourage the development of a not-for-profit sector that will provide services that the for-profit sector will not provide because there is minimal to no profit in it, and that the government can only provide at exorbitant cost to the taxpayer. The not-for-profit sector is expected to provide services that no-one else wants to provide in an efficient and cost-effective way. We do that. However, in New York, the state insists on continuing to be a provider of the same services as the not-for-profits but at costs that are substantially higher. A not-for-profit sector mental health direct care staff person makes half what a comparable state worker makes with corresponding disparities in benefits. First line managers make approximately one-third what a first line state manager makes. We could ask the fundamental question, which is why the taxpayer should tolerate the exorbitant cost, but that's a discussion that is beyond this session, and one that can only be answered in the context of politics, power, and money. So I'll move on.

The state should do what OMRDD has done, i.e., develop community-based programs that re-deploy the state workforce while adequately funding the not-for-profit sector. All but a few of the state psychiatric hospitals should be downsized and closed, with community based residential options developed that would serve the displaced consumers and that would re-deploy the state workforce. This must be accomplished with two things in mind, however. First the programs must be as integrated into the community as possible. Some could be built on the fringes of existing state facility properties, but only if they are also kept relatively small. Residential Care Center for Adults or RCCA's are not the preferred option. They are large and institutional, and merely replace one institutional setting for another. However, additional state operated community residences with the enriched staffing patterns that they currently enjoy could serve "high risk high need" individuals on a transitional, step down basis. They could also serve as hospital diversion programs that try to stabilize a person's acute symptoms with hospitalization used as a last resort. They could also be the provider of preference for that small group of consumers that are enrolled in AOT, or who are AOT diverted, who have documented histories of the most worrisome behaviors.

Further, the disparity between not-for-profit and public sector salaries must be substantially decreased to stop the continuing erosion of the workforce in the not-for-profit sector. This is a necessary and minimum step to insure the viability of the community based mental health system. Public employee unions must actively and publicly support substantial increases for the not-for-profit sector, and cease working in any way to suppress wages in that sector. The community-based system has never opposed wage increases for the state workforce, even when state workforce increases translated into cuts on the community side during particularly tough budget years.

In summary, we ask that MHANYS support the immediate stabilization of the voluntary sector residential programs. Then, there should be a concerted effort on the part of all mental health advocates and stakeholders to develop a new system of care that is outcomes based, where realistic program expectations are developed with funding levels in mind, and where there is a true partnership between the state and the voluntary providers to provide the best care to that core group of individuals with severe and persistent mental illness who are the most in need.

Thank you.

1991 to 2002 Cumulative Comparison of the Consumer Price Index – the OMRDD HCBS Residential Trend – and the OMH CR Residential Funding Changes

50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%

1991-1992 1992-1993 1993-1994 1994-1995 1995-1996 1996-1997 1997-1998 1998-1999 1999-2000 2000-2001 2001-2002 2002-2003