

ACL
Association for Community Living
99 Pine Street, Suite 202JR
Albany, NY 12207
(518) 426 - 3635

JOINT SENATE/ASSEMBLY
LEGISLATIVE HEARING ON THE 2003 –2004 BUDGET

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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, including approximately 20,000 housing opportunities with supports.

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 series of articles in the Times Union about consumers in jail must lead to one conclusion: *that housing for people with psychiatric disabilities must be one of the state's highest priorities.*

We thank the governor for his commitment to building and opening 2,600 units of housing for people with psychiatric illnesses over the next 7 years or so. Although this is a good start, more needs to be done, particularly given the following facts:

- During the last 9 years, people were discharged from state psychiatric facilities;
- The Governor has reported to the press that his administration has brought as many as 5,000 people with psychiatric disabilities back to NY from out of state placements;
- There are as many as 15,000 with psychiatric disabilities who are homeless;
- There are as many as 8,000 with psychiatric disabilities who are in jails and prisons;
- There are many people with psychiatric disabilities that were discharged from state institutions to their parents' home – these parents are becoming too elderly to care for their ill children, and placements will need to be secured.

Clearly, 2600 units are insufficient.

In addition, the existing mental health housing system funded and regulated by the State Office of Mental Health is in serious financial and programmatic jeopardy. In fact, they are no further ahead financially than they were in 1995, at the beginning of this

governor's tenure, while at the same time they are serving more and more high need, high risk clients.

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 residential programs funded by the State Office of Mental Health. As you can see from the chart, OMRDD waived 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 *including the 3% COLA that they just received in December 2002*.

The second chart contrasts state wages v. private not-for-profit reimbursement levels for the same exact program with the exact same number of beds that follow the same exact state regulations.

The third chart is the results of a medical conditions survey that we conducted last year. In addition, our staff manages an average of 8 medications per client compared to 2 medications per client 20 years ago. In some areas of the state as many as 75% of our client population has a substance abuse disorder. In addition, as you all know, the legislature passed Kendra's Law, creating an immediate mandate for residential programs to serve high risk, high need consumers, and AOT consumers. We regularly have AOT court-ordered clients in our programs. However, dollars appropriated for Kendra's Law initiatives *did not* make their way to residential providers.

We can no longer attract or retain qualified staff resulting in interruptions in care, and inadequate care. Staffing ratios, educational 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. There are hundreds of medications, as well as complex medical conditions and behavioral issues to manage. Our annual staff turnover rates are at 50% so that our first line managers are often filling in overnights and weekends, resulting in severe "burn-out." In an effort to keep the programs intact, more and more agencies have shifted administrative dollars to direct care – but this puts regulatory, reporting and administrative compliance in serious jeopardy.

We ask that you make stabilizing the residential base the highest priority this year because frankly, it is impossible for not-for-profit residential providers to continue to function in this way.

- The licensed Community Residence program needs an immediate one-time increase to its Medicaid rate. If this is not possible we make the following suggestions for relatively low-cost relief:
 - Add an additional full time equivalent staff person to each program. This was done last year for the children's community residences. The same should be done for the adult programs.
 - Extend the existing mental hygiene law that allows for dollar for dollar reimbursement of property costs (the 41:38 pass through) to insurance, transportation and food.
- Supported Housing stipends need to be sufficient, and based on cost. They need to cover rents, staff transportation, 1:15 staff ratio, office expenses, and an

administrative share. Reinvestment beds should keep up with increases in state funded beds. In addition, 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. The attached chart shows the shortfall in the stipend for each county in the state.

- Enhanced service packages should be created immediately for those programs 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.

I, and many of my colleagues in the mental health system have complained year after year about funding inadequacies. It’s been no different in good times or in bad times, because there is no adequate long-range plan in place for the mental health system. Realistically, the state cannot support both a substantial state institutional system as well as an adequate community based system. There are only 4500 patients left in state institutions from 93,000, with over 20,000 beds in the community, however, a disproportionate share of the dollars go to the hospitals.

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 because the government can only provide it 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 one 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 ask a fundamental question, why should the taxpayer tolerate the exorbitant cost of state facilities when cooperation with the not-for-profit sector will yield quality services at reasonable cost?

There is a role for public employees to play in any plan that is developed, however, any long-term program plan must resolve the long-standing and growing disparity in wages between the public and private sectors. In addition, it 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. 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. Residential providers stand ready to provide that localized system as long as they are reimbursed adequately so that they can operate the programs in a safe and prudent manner.

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 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.

In summary, we ask that you support the immediate stabilization of the voluntary sector residential programs. Then, there should be a concerted effort to develop a new system of care that can be outcomes based, but 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.

It has long been ACL's position that there is a fairly consistent baseline number of citizens in New York State who have a severe and persistent psychiatric disability, who are functionally impaired, and who are poor, that are a priority for the state. Until there is a cure for mental illness, the state's commitment to this core group 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. Governor Pataki re-iterated his commitment to the mentally retarded in his state of the state, promising a housing placement for every individual who needs one. Where is the corresponding commitment to the mentally ill, who are no more responsible for their illness as a mentally retarded person is for theirs?

Thank you.

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

