



**THE CENTER FOR POLICY, ADVOCACY, AND EDUCATION
OF THE MENTAL HEALTH ASSOCIATION OF NEW YORK CITY**

POSITIONS ON MENTAL HEALTH POLICY ISSUES
2012

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POSITIONS ON MENTAL HEALTH POLICY ISSUES 2011

The Mental Health Association of New York City is committed to the progressive development of comprehensive, community-based mental health services based on the following core principles:

- There is a fundamental right to live in the community.
- Mental health services should be responsive to the needs and choices of, and accessible to, all people with mental health problems—to children, adults, and older adults; to people with severely disabling conditions and those with mental health conditions which are not severely disabling; and to people from all ethnic and racial groups.
- A broad range of services is needed including crisis intervention, outpatient treatment, housing, rehabilitation, case management, community support, inpatient treatment, prevention, and mental health promotion services.
- Mental health services should be available in specialized mental health programs and organizations **and** as a fundamental element of the mainstream health care system depending on the needs and preferences of the population served.
- Services should be of high quality. I.e., they should be empirically validated or, when research has not yet yielded evidence-based practices, they should reflect expert consensus.
- This requires a clinically and culturally competent workforce of adequate size to meet the needs of the broad population noted above. This entails increasing both the size and the competence of the workforce through enhanced recruitment, education, and training.
- To be effective, mental health services require (1) strong coordination and collaboration among specialized mental health providers--both public and private—and (2) integration of mental health services with other helping systems such as health, substance abuse, aging, child welfare, education, juvenile justice, affordable housing, and public entitlements.
- Research focused on best practices and outcomes is essential.
- Adequate public funding should be made available to implement these principles.

The purpose of this document is to present the positions of The Mental Health Association of New York City on specific mental health policy issues. The issues are presented in alphabetical order.

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ACCESS

Access to needed mental health services is frequently limited because of (1) lack of available services, (2) lack of mobile, home or community-based services, (3) lack of information about services, (4) lack of adequate insurance coverage, (5) high cost, (6) restrictive eligibility policies, (7) lack of cultural competence (8) restrictive drug formularies, or (9) lack of transportation. MHA believes that all people should have unrestricted access to a full-range of needed mental health treatment and rehabilitation services. Therefore, we support efforts to increase access and oppose all policies and practices which unreasonably restrict access to needed services.

ADULT HOMES

Over the past quarter century there have been recurrent exposés about the quality of care for the 12-15,000 people with serious mental illnesses in New York State (NYS) who live in adult homes—i.e., congregate care facilities designed to provide room and board to poor people who cannot live independently. Each revelation has been followed by a new “commitment” to improve monitoring of adult homes, to strengthen enforcement of regulations, and to expand and improve services. None of these changes has resulted in long-term improvements, and none has addressed the problem that adult homes are dead-ends for people with mental illnesses, offering virtually no opportunity for recovery or a transition to independence.

A recent court ruling found the state to be in violation of the Americans with Disabilities Act by keeping 4,300 people with mental illness in adult homes and ordered the state to begin to transfer these individuals into more integrated settings. Implementation of this ruling is on hold pending appeal by the state. MHA is disappointed that NYS did not accept the ruling and hopes that it withdraws its appeal. If this does not happen, MHA will continue to support the effort to persuade the appeals court to support the decision of the lower court.

MHA also believes there must be a fundamental change of policy. Adult homes should not be used to house people with serious mental illnesses. In addition to developing the housing that hopefully will be required by the court, The NYS Office of Mental Health (OMH) should be charged with developing a long-term plan to end reliance on adult homes. Over a reasonable period of time, additional appropriate, alternative housing should be developed. During the period of transition, OMH should oversee “impacted” adult homes and assure decent mental health and health care service provision. This approach would not preclude adult homes from becoming the locations of specialized mental health housing if they meet appropriate standards regarding program services and physical plant.

AUSPICES

New York State has a rich mix of mental health service providers including programs run by the state, many counties, and the federal Department of Veterans’ Affairs. There are also programs run by not-for-profit and for-profit organizations including community mental health agencies and general hospitals. In addition, private practitioners serve a very large portion of people with mental illness who get treatment. MHA believes that this kind of diversity is beneficial and will support maintaining it.

CHILDREN AND ADOLESCENTS

Many children and adolescents with emotional disturbances do not get mental health services; and many of those who do get services—especially those who are most seriously emotionally disturbed—do not get appropriate services. In addition, recent research shows that many adult health and mental health problems result from untreated child behavioral problems and trauma, highlighting the importance of prevention and early intervention.

Over the past two decades, NYS has taken several steps to address issues of child and adolescent mental health. But MHA believes that substantially more resources need to be committed to children and adolescents and their families to fully address their mental health needs. MHA therefore supports:

- Continued efforts to develop a comprehensive community-based system of care for seriously emotionally disturbed children and adolescents
- Increased flexibility so as to be able to provide the right service, at the right time, in the right place
- Improvements of mental health services in schools, in the child welfare system, and in the juvenile justice system
- Increased collaboration among child-serving systems
- Increased coordination between pediatricians/family physicians and the mental health system
- A central role for families in service planning and delivery
- Enhanced capacity for early intervention
- The development of interventions to promote emotional resilience
- Increased research designed to improve psychotherapeutic and pharmacological treatment and other mental health services
- Expanded training in state-of-the art practices including pharmacological and psychotherapeutic interventions so as to enhance clinical and cultural competence
- Health insurance that provides full coverage for treatment of mental disorders and parity with coverage of physical illnesses.

CLINIC REFORM

Several years ago The New York State Office of Mental Health started a multi-year initiative to restructure the way mental health clinics deliver and get reimbursed for care. The new rate system was designed to meet federal requirements and to provide payment for improved clinic services. For example, had it been approved by the Centers for Medicare and Medicaid Services (CMS), higher rates would have been paid for home visits, and there would have been special rates for outreach and engagement activities. Sadly, these progressive changes were dropped because of concern that CMS would reject them. NYS decided to pay for offsite services for children without federal financial participation but not to go ahead for adults or—very importantly—for older adults, many of whom are homebound. MHA will advocate for off-site services and outreach and engagement services to be covered in the new system.

The state has instituted utilization controls for mental health clinics. The threshold for adult annual visits over 30 is a 25% cut and for annual visits over 50 it is a 50% cut. For children, there is 50% cut for annual visits over 50. MHA is concerned that the thresholds will have a

negative impact on some people with serious and persistent mental illness and children with high, complex needs. MHA will advocate for exceptions for high need patients.

CONFIDENTIALITY OF PATIENTS' RECORDS

Because of the information systems that are available to insurance companies, managed care organizations, networks of providers, and governmental bodies and because of the requirements of the Health Insurance Portability and Accountability Act (HIPAA), great concern has arisen about the confidentiality of patient information. While MHA supports uniform information reporting systems and improved communication among providers, we also believe that access to confidential information should be guided by patient's consent and considerable need. In addition, in an effort to more effectively coordinate and integrate care, substance abuse information should not be excluded from being shared. MHA will evaluate specific proposals regarding sharing information about patients on the basis of a need to balance privacy and to improve service integration.

CONSUMER AND FAMILY PARTICIPATION

NYS has made a commitment to involve consumers and families, and their participation is unquestionably more extensive than in the past. MHA believes that consumer and family participation is critical and should be enhanced at all levels including:

- Treatment planning
- Program development
- Systems planning
- Evaluation and oversight.

CO-OCCURRING DISORDERS

Co-Occurring Mental and Addictive Disorders

Many people with serious mental disorders also suffer from addictive disorders, and it is widely known that integrated treatment approaches work best for this population. Unfortunately, integrated treatment continues to be the exception rather than the rule. This failure reflects schisms of ideology and treatment philosophy, impermeable bureaucratic boundaries between public systems, and disdainful distance between mental health and substance abuse professionals.

Over the past 30 years, several efforts have been made to improve collaboration between OMH and OASAS so as to facilitate integrated treatment. There have been modest improvements as a result. A few years ago, a new task force made recommendations for extensive change, some of which is underway. These recommendations call for the delivery of integrated mental health and substance abuse services in both systems without requiring dual licensure. MHA strongly supports this approach because dual licensure is an administrative nightmare that impedes integrated service delivery. In addition, MHA opposes merger of the two departments. In fact, we believe that expectations of inter-agency collaboration—which has failed historically—should be kept to a minimum and that the state should focus on integrated treatment in practice rather than on extensive collaboration between the bureaucracies.

Co-Occurring Physical and Mental Disorders

See section on integration of physical health and behavioral health services – page 13.

Co-occurring Developmental Disability and Mental Illness

Over 40% of people served in NYS’s developmental disability system also have psychiatric diagnoses. Yet, there is very limited coordination with the mental health system. People with mental illness and a developmental disability frequently need specially designed services, which are in short supply in NYS. MHA supports the establishment of an initiative to determine how best to meet the needs of these people and the continued development of specialized housing and community services for this population. MHA also supports the use of dispute resolution procedures that effectively determine whether OMH or OPWDD is responsible for particular people whose primary needs are not immediately clear.

COORDINATION AND RESPONSIBILITY

Under the current system, providers’ responsibility for their clients is limited to providing certain kinds of services. There is limited collaboration among providers, a lack of clarity about who is responsible for clients outside of their service programs, and limited flexibility to provide critical supportive services in community settings. It is essential to address issues related to enhanced coordination among providers and to developing clarity about responsibility for people with mental illnesses. MHA advocates for systems changes which enhance:

- Responsibility for people served
- Service integration within the mental health system
- Service integration between the mental health system and other systems serving people with mental illnesses
- Flexibility to respond to individual needs and preferences.

The expansion of Medicaid managed care and the development of “health homes” are intended to achieve these goals. Whether they will succeed in improving access to, and quality of, care is yet to be seen. MHA will follow these developments carefully and take positions based on the principles above.

MHA is also supportive of efforts to improve coordination of physical and behavioral health in primary, specialty, and long-term health settings. Hopefully, the development of “medical homes” will help to achieve this. MHA will monitor the developments and comment on what actually takes place in accordance with the principles above.

COST OF LIVING ADJUSTMENTS (COLA)

Cost of living adjustments are essential every year. Therefore, MHA will press NYS to respond to the ongoing threat to the infrastructure of the mental health system by advocating for an automatic annual increase in Medicaid and other mental health service funding streams to keep pace with inflation.

CRIMINAL JUSTICE AND MENTAL ILLNESS

A large proportion of all prison and jail inmates in the United States have a mental illness. This has fueled suspicions that a significant number of people who presumably have been “deinstitutionalized” from the mental health system have, in fact, been “transinstitutionalized” to the criminal justice system.

To improve response to people with serious mental illnesses who are caught up in the criminal justice system, MHA advocates for:

- Research to clarify the extent of inappropriate incarceration of both adults with serious mental illnesses and adolescents with serious emotional disturbances
- Improved police interventions including
 - Enhanced police training
 - Establishment of specialized police crisis intervention teams to intervene with people who have mental illness
- Establishment of jail diversion and treatment alternatives programs
- Expansion of mental health courts
- Access to good mental health services outside of jails or prisons for people who are seriously mentally ill and commit relatively minor crimes
- Improved mental health services in jails and prisons
- Elimination of the use of solitary confinement for prisoners with serious mental illnesses (A bill has been passed to do this, but it has not yet been implemented.)
- Coordinated discharge planning at release from jails and prisons with tight linkages to mental health services
- Coverage for the costs of mental health treatment and medications for people released from jails and prisons.

CULTURAL AND LINGUISTIC COMPETENCE

With the growth of minority populations, providing culturally and linguistically competent services is increasingly important. MHA supports the development of greater cultural and linguistic competence including:

- Increased availability of bi-lingual mental health professionals and of good translators
- Improved access of cultural minorities to high quality service providers in the private as well as the public sector
- Improved engagement of cultural minorities in mental health programs
- Improved clinical services to culturally diverse people
- Increased training for current and future providers
- Creation of incentives to encourage minorities to become mental health professionals
- Enhanced recruitment and hiring of professional and other staff from cultural minorities
- Fair promotional opportunities
- Dealing with race relations issues in mental health programs and facilities.

DISASTERS

MHA recognizes the important role mental health plays in disaster preparedness and response. To effectively prepare for and address the mental health needs of disaster victims, MHA advocates for:

- Development of a local mental health disaster response entity
- Development of a local mental health disaster plan including
 - Development of a telephonic and communications hub to provide information, referral, and emotional support
 - Outreach and crisis response
 - Public mental health education
 - Access to a range of short and long-term mental health services in the aftermath of a disaster
 - Coordination of services in the public and private sectors
 - Public communication to alleviate fear of disasters
- Integration of mental health services with crisis response and concrete services as well as mental health services in normative settings
- Cadre of trained personnel who are clinically and culturally competent to respond to the mental health needs of disaster victims
- Training and support for people providing help
- Organization of social support and mutual aid networks
- Funding to pay provider organizations and to help people pay for treatment

EMPLOYMENT OF PEOPLE WITH PSYCHIATRIC DISABILITIES

MHA believes that efforts to help people with long-term psychiatric disabilities to become employed should be a major priority for NYS. This includes the development of more employment programs. It also includes inducements to employers to hire and retain people with psychiatric disabilities—such as tax credits to reduce the costs of compensation. It should also include fostering employment incentives through SSDI, SSI, Medicare and Medicaid while protecting the benefits of people with psychiatric disabilities.

FAMILY SUPPORT

Family caregivers are the major source of care for people with disabilities, and family caregivers are at high risk for mental and physical illnesses.

MHA advocates for family support initiatives for:

- Families with seriously emotionally disturbed children and adolescents
- Families of adults with psychiatric disabilities
- Families caring for disabled older adults
- Kin caregivers (grandparents, aunts and uncles, older brothers and sisters, and other family and friends)

These initiatives should include education, respite, expanded mental health services, assistance with future care planning, and tax and entitlement policies to ease family burden.

FEDERAL FUNDING CUTS

Efforts are now underway to reduce federal spending. President Obama has proposed a package of spending cuts and revenue enhancements that include over \$300 billion of cuts to Medicare and Medicaid over the next decade. These cuts to entitlement programs are likely to have a negative impact on those most in need, including people with serious mental illness who rely on these funding streams to pay for their care.

MHA will advocate against any approach that converts entitlements to funding streams that do not guarantee to pay for care for eligible people in need of care. For example, it will advocate against converting them to block grants.

MHA will also look carefully at any proposed cut and if it will result in a loss of needed services, it will oppose the proposal.

FUNDING FOR MULTI-YEAR SERVICE EXPANSION

MHA advocates for a multi-year commitment to provide annual funding increases to support the progressive development of a comprehensive, community-based mental health system with the capacity to serve all in need. MHA advocates that the funding be multi-level with local, state, and federal support. MHA also advocates that the funding of mental health services come from all possible funding sources including Medicaid, Medicare, pooled funding from the child welfare, juvenile justice, and aging service systems, VESID, Special Education, Tobacco settlement funds, and more.

MHA is concerned that the determination of government to cut spending on mental health, especially Medicaid spending, will result in the loss of critical services. It is possible that expanded managed care will result in more accessible and better care while also holding down spending, but this hope is far from certain. MHA will monitor the expansion of managed care and take positions about it and other cost control measures depending on the extent to which they are consistent with the need to increase and improve mental health and related services that are critical to people with mental illness.

GENERAL HOSPITALS

General hospitals provide approximately 1/3 of mental health and substance abuse services in NYS. In 2006 MHA led a Taskforce that successfully advocated to protect the general hospitals from cuts to their behavioral health services due to downsizing recommendations by the Hospital Closure Committee.

In 2011, NYS's Medicaid Redesign Team formed a Health System Redesign Brooklyn Work Group to assess the strengths and weaknesses of Brooklyn hospitals and their future viability. The Work Group recommended closing a number of general hospitals in Brooklyn so as to

reduce Medicaid expenditures. This will result in the loss of inpatient and outpatient psychiatric services currently provided by general hospitals. MHA believes that loss of capacity to provide psychiatric services in general hospitals would jeopardize NYS's community-based system of care, which has relied heavily on general hospitals over the past quarter century to pick up the slack caused by the closing of state psychiatric facilities. Any reduction of psychiatric service capacity in a general hospital must be combined with a transfer of capacity to another local facility and/or the development of community services that would reduce current inpatient need.

MHA will continue to work to protect needed services in general hospitals.

GERIATRIC MENTAL HEALTH AND ADDICTION SERVICES

Currently there are insufficient and inadequate mental health and addiction services for older adults, and the aging of the baby boom generation will bring a large growth in the number of older adults in need of such services. MHA believes that government at all levels must focus far more attention on the behavioral health needs of those who are now elders and the needs of future generations. This includes:

- The development of long-term, inter-agency plans for geriatric mental health and addiction services at federal, state, and local levels
- Expansion of geriatric mental health and addictions services especially in home and community settings
- Integration of physical and behavioral health services in primary, specialty, mental health, and long-term care
- Integration of behavioral health and aging services
- Improvement of geriatric mental health and addictions services in institutional and community service settings
- Improved funding through
 - Optimization of existing funding streams (especially Medicare),
 - Modification of funding structures to support home and community-based services and service integration, and
 - Increased funding.
- Development of a workforce with clinical, cultural, and generational competence and which is large enough to match the growth of the aging population
- A research agenda for geriatric mental health that will contribute to improved services in all systems serving older adults with mental and/or addiction problems.

HEALTH AND MENTAL HEALTH PROMOTION

In addition to its support for accessible, high quality treatment and support services for people with mental illness, MHA supports the provision of services that promote the maintenance of mental health and that help to build emotional resilience. MHA also supports efforts to improve the physical health and increase the life expectancy of people with serious mental illness. Currently this effort includes (1) "wellness" activities, (2) improved access to primary health care, and (3) improved coordination of physical and behavioral health services. MHA believes that these efforts need to be expanded to include suicide prevention activities and a strategy to

help people with serious mental illness, especially those who also abuse substances and those who are homeless, to avoid the dangers of the street.

HEALTH CARE NEEDS OF PEOPLE WITH LONG-TERM PSYCHIATRIC DISABILITIES

People with long-term psychiatric disabilities have a life expectancy that is 10-25 years less than the general population mainly because of poor health but also because of high rates of accidents and suicides. Chronic health conditions such as obesity, hypertension, diabetes, heart disease, and pulmonary conditions are common among this population. In addition, lack of access to good health care and lack of coordination among mental health and health providers pose great challenges to adequately addressing their health care needs.

MHA believes that efforts to improve the physical health of people with long-term psychiatric disabilities should be a major priority of the mental health system. This includes improving access to good health care; integrating health with mental health services; and wellness approaches that emphasize smoking cessation, weight loss, exercise, and adherence to dietary restrictions; disease management; and peer health coaching. MHA believes that these efforts need to be expanded to include suicide prevention activities and a strategy to help people with serious mental illness, especially those who also abuse substances and those who are homeless, to avoid the dangers of the street.

MHA supports and will monitor efforts in the recently passed health care reform law to foster improved health care for individuals with long-term psychiatric disabilities.

HEALTH POLICY REFORM AND BEHAVIORAL HEALTH

Health policy reform offers significant benefits to people with mental illness. (1) Many people with mental illness who are not currently covered will get health insurance. (2) Mental illness will be covered at parity with physical illnesses. (3) There are incentives to improve coordination of physical and behavioral health services. (4) There is an expansion of home and community based options.

MHA supports the Affordable Care Act and will oppose efforts to rescind it.

HOUSING

Stable housing is critical for children, adults, and older adults with mental illness, but there are substantial unmet housing needs.

MHA advocates that:

- Funding for existing housing should keep pace with market changes in compensation and housing costs
- Funding models reflect changing populations in OMH and other housing programs
- Development of new housing should continue.

Although MHA supports the effort to make mainstream housing available for people with serious mental illness, we also advocate for continued expansion of specialized housing for people with serious and persistent mental illness, especially those with co-occurring disorders.

In addition, because the only available information about housing need is out of date, MHA believes that OMH should conduct a new needs assessment. At the very least OMH should develop a waiting list of people with mental illness who need housing like the waiting list used by OPWDD.

HUMAN RESOURCES

The provision of high quality mental health services depends on the availability of staff who are both humane and knowledgeable about state-of-the-art technology. MHA believes that the development of high caliber mental health staff is of central importance to the mental health system and therefore will advocate for (1) a living wage for all mental health workers, (2) spread of state-of-the-art practices, (3) enhanced recruitment of culturally and linguistically competent staff, especially those from minority cultures, and (4) use of people with mental illness and their family members as paid staff.

INTEGRATION OF PHYSICAL HEALTH AND BEHAVIORAL HEALTH SERVICES

Integration of physical and behavioral health care has become a major goal in health and behavioral health policy in the United States. This is reflected in recent health care reform legislation and in a number of other policy initiatives at the national level and in New York State. Integration of care is critical for several reasons. (1) People with serious mental illness have a life expectancy 10-25 years less than the general population because of poor health and poor health care. (2) People with co-occurring severe health and mental health conditions are among the most expensive Medicaid cases because they do not get timely, effective treatment. (3) Depression complicates physical illnesses such as heart disease, resulting in increased risk of disability, lowered life expectancy, and much higher medical costs. (4) Many people putatively in nursing homes because of physical disabilities are actually there because of mental and behavioral problems or because of the emotional and physical toll on family caregivers.

MHA supports broad-based efforts to integrate mental and physical health services including:

1. Building screening, assessment, and treatment for mental health and substance use problems into primary health care
2. Building primary health care into programs for people with serious and persistent mental illnesses
3. Improving identification and treatment of mental and substance use disorders in specialty practices
4. Dealing adequately with behavioral health needs in long-term care programs—both community-based and institutional

5. Aggressive efforts to identify, reach out to, and engage those with co-occurring severe behavioral and physical disorders that are likely to result in recurrent crises and the need for intensive, extensive, and expensive treatment.
6. Using technology to integrate care, e.g. telepsychiatry
7. Using psychosocial interventions to build resiliency and to help people make changes in behavior and lifestyle, such as diet and exercise to promote good physical and mental health

In addition, while health care reform emphasizes the need for coordinated and integrated care, including the development of medical homes and integrated delivery system models, mental health is not always adequately addressed. MHA supports the integration of mental health in the development of medical homes and coordinated care models. In addition, mental health clinics should be able to serve as medical homes for people with serious mental illnesses who typically receive most of their care from a mental health provider.

For further detail see MHA's position paper on integrating physical and behavioral health services.

INVOLUNTARY OUTPATIENT COMMITMENT

Involuntary outpatient commitment was established in NYS in the hopes of improving the clinical condition of, and reducing violence committed by, people with serious mental illnesses who reject treatment. It is critical to be clear that the effectiveness of involuntary outpatient treatment depends almost entirely on the provision of extensive outreach, treatment, and community support services, which must be adequately funded to be effective. MHA believes that involuntary outpatient commitment should not be a major element of NYS's efforts to serve people who reject traditional treatment. Rather this measure should be used only as a last resort for those people who do not respond to aggressive outreach and community treatment without a court order. MHA also calls for additional research and outcome data on the effectiveness of this treatment approach.

LONG-TERM CARE

A high proportion of individuals in nursing homes, assisted living, adult day care, or receiving home health services have diagnosable behavioral disorders. New York State has adopted a long-term care reform agenda that focuses heavily on reducing the use of nursing homes by providing community-based alternatives to institutions. However, the state's reform initiatives have not adequately addressed the fact that behavioral disorders in older adults and in their family members are major reasons for institutional placement.

In order to adequately address behavioral health issues in long-term care, MHA advocates for:

- Recasting NYS's long-term care restructuring initiatives to recognize the importance of behavioral health
- Increasing access to, and integration of, mental health, health, and aging community-based services
- Improving quality of long-term care services for people with behavioral health problems.

- Providing far more support for families caring for family members with disabilities who are at risk of placement out of their homes
- Developing housing alternatives to nursing homes for people with co-occurring serious mental and physical disabilities.

MANAGED CARE

Managed behavioral health care has become a major element of America’s mental health system, and it is increasingly viewed as THE way to contain Medicaid spending on people with behavioral health problems—especially those with co-occurring serious behavioral and physical disorders.

(1) MHA does not oppose the continued utilization of managed care in both the private and the public sectors. However, we believe that managed behavioral health care should:

- Respect patients’ rights to high quality services, access to information, access to medications, rapid appeals, choice of competing managed care plans, and to sue managed care organizations for malpractice
- Limit cost transfers from the private sector to the public sector
- Cover non-traditional community-based services designed to avert the need for inpatient care
- Support the survival of community agencies and general hospitals that provide needed behavioral health services
- Proceed cautiously with regard to people with serious and persistent mental illnesses, whose needs, for the most part, cannot be met with a basic managed behavioral health care plan.

(2) MHA is concerned that the rhetorical promise of increased Medicaid managed care will not be fulfilled in reality. It, therefore, will monitor implementation carefully and take positions based on meeting the needs of people with serious mental illness in reality as well as in concept.

MEDICAID

As noted above, Medicaid is in jeopardy at the federal level. Protecting it as an entitlement is critical because, over the past four decades, Medicaid has become the major source of funding for public mental health services. Despite repeated efforts to cut Medicaid funding for mental health, it has continued to grow. MHA supports continued expansion of Medicaid for mental health.

The health care reform law expands Medicaid coverage to include individuals with incomes at or below 133% of the federal poverty level. MHA supports this as well.

MHA also supports NYS’s ongoing efforts to increase federal financial support for mental health services through Medicaid, so long as it remains possible to provide services using effective (sometimes non-medical) models. In general, we will advocate for a return to a policy of using Medicaid to increase services rather than to reduce state and local costs.

As noted above, MHA is concerned about the *implementation* of plans to expand Medicaid managed care in NYS and will monitor the process and take positions that reflect the need for better access to mental health and other services for people with mental illness.

Medicaid for Long-term Care

Medicaid also is the largest payer for long-term care services such as home health, adult day care, and nursing homes. Many of the people who receive these services have significant mental health problems, but Medicaid for long-term care is not designed to support high quality mental health interventions in these settings. MHA advocates for changes in Medicaid to better address the mental health needs of people in long-term care.

Access for Medicaid recipients

Unimpeded access to appropriate and high quality psychiatric treatment, rehabilitation, and medication is critical to Medicaid recipients. MHA opposes any and all barriers to access to psychiatric services—whether financial or procedural. Specifically:

MHA opposes any effort to limit access to the most appropriate psychiatric medications as determined by a person's physician. Thus, it is unacceptable to:

- Establish drug formularies that restrict appropriate access to psychiatric medications
- Impose procedural requirements that delay access to clinically appropriate medications prescribed by physicians.

MHA does not oppose a requirement to use clinically equivalent generic drugs instead of brand name drugs.

MEDICARE

As noted above, Medicare funding is in jeopardy at the federal level. It is critical to preserve Medicare as an entitlement and to preserve its coverage of mental health services despite the fact that Medicare as structured creates significant barriers to the provision of high quality mental health services for older adults and people with psychiatric disabilities who qualify for SSDI.

In the past MHA has called for extensive reform of Medicare to deal with limited coverage of home and community-based services, geriatric psychiatrists opting out of Medicare and other issues. At the present time, however, the most pressing need is to preserve Medicare as an entitlement.

MENTAL HEALTH IN THE MAINSTREAM VS. SPECIALIZED SERVICES FOR PEOPLE WITH SERIOUS AND PERSISTENT MENTAL ILLNESS

Currently, there is a debate about whether mental health policy should reflect integration into mainstream healthcare or if it should remain largely a separate policy arena as it has been historically. Because MHA believes that people with psychiatric disabilities have critical needs

that are not addressed via mainstream health policy, MHA supports both improved integration of physical and behavioral health and the retention of a specialized mental health system.

OUTREACH TO HARD-TO-SERVE POPULATIONS

Many adults with serious and persistent mental illnesses and kids with serious emotional disturbance reject or are unable to use traditional treatment services. Some of them are able to lead stable lives which they find satisfying. Others experience frequent crises, which often result in hospitalization. Some are in and out of homelessness. A growing number are in jails or prisons, generally for minor crimes. A very few commit acts of violence. This “hard-to-serve” population often has co-occurring substance abuse disorders and/or serious physical illnesses and, therefore, tends to be the most expensive Medicaid cases.

This population can be served effectively if appropriate services are available and accessible. Particularly important are assertive outreach efforts and the provision of services in places (including their homes) and in ways people who tend to reject traditional services will find acceptable.

MHA believes that there should be continued expansion of special services for this population. In addition to supported housing and case management, this should include continued expansion of initiatives to provide assertive outreach and community-based treatment services.

PARENTS WITH PSYCHIATRIC DISABILITIES

People with serious mental illnesses who are parents often do not get support that would help them be effective parents. In many cases, their children are removed from their custody because of concerns about their potential for abuse or neglect. Such concerns are sometimes justified by their actual behavior; sometimes they are based on misconceptions about people with psychiatric disabilities.

MHA believes that:

- Psychiatric rehabilitation should include assistance to be effective parents
- Supported and supportive housing should include units for families living together
- Laws that permit the state to take custody of children solely because they have a mental illness should be eliminated.

PARITY

MHA believes that public and private health plans should provide people access to mental health care and that such coverage should be equal to health benefits.

Parity has been built into the Affordable Care Act. MHA will monitor implementation and support whatever actions are needed to make parity a reality.

In addition, MHA believes that improved mental health benefits can be achieved through changes to workplace mental health policies instituted voluntarily by employers. We will continue to work to bring about such voluntary changes. (See page 26.)

PATIENTS' RIGHTS

Managed care

MHA supports a variety of patients' rights regarding managed care. (See section on managed care. – pg. 15)

Treatment rights

MHA also supports a broad array of rights related to treatment, which include the right to participate in treatment planning, the right to refuse treatment except when incompetent, the right to remain in contact with the community when in a hospital, etc.

PEER SUPPORT AND SELF-HELP INITIATIVES

Over the past decade, NYS has done a great deal to foster the development of a consumer movement and to put in place a variety of peer support and self-help initiatives. MHA believes that these have been very helpful to people with mental illnesses. Continued expansion of peer support and self-help initiatives, including for promoting healthy lifestyles, is an essential element of the efforts that need to be made to reach hard to serve populations and to open mainstream opportunities to people with serious and persistent mental illnesses.

PERSONALIZED RECOVERY ORIENTED SERVICES (PROS) WHERE DO WE STAND WITH THIS?

Although “Personalized Recovery Oriented Services” (PROS) is resulting in improvements in the treatment and rehabilitation for people with serious mental illnesses, key questions still need to be answered regarding (1) the adequacy of funding, (2) the impact of changing service models on consumers, and (3) the long-term viability of substituting Medicaid for state aid. MHA, therefore, supports continued slow phase-in of the new programs with careful evaluation.

PLANNING

MHA believes that NYS should engage in a population-based mental health planning process as required by Pt. 5.07 of the Mental Hygiene Law. Over the past few years OMH has provided such a plan, but the plans have not provided adequate data about needs or quantified commitments regarding program expansion. We believe that it can be improved by:

- Including up-to-date, quantified needs assessments
- Including multi-year, quantified projections of service changes and development.

PREVENTION, EARLY IDENTIFICATION, AND EARLY INTERVENTION

From its inception, the Mental Health Association movement has been committed to prevention.

Our position is:

- Prevention of mental illness is a fundamental hope, and the effort to discover ways to prevent mental illness is of utmost importance. Research regarding the development of preventive interventions should be well supported.
- Preventive intervention techniques and efforts to build emotional resilience that are supported by research should be widely implemented. Preventive interventions which are not supported by research should be implemented only on a limited scale as part of carefully evaluated demonstration projects.
- Prevention of hospitalization by providing alternative services in the community should be a core goal of community mental health.
- Early intervention often makes it possible to prevent problems of mental health from becoming severe and/or disabling. For this reason early identification (especially in non-mental health settings) and early intervention are important components of a sound community mental health system.
- The most severe mental illnesses tend to recur. Therefore, relapse prevention should be a major goal of the treatment of people with recurrent psychiatric disorders.
- Relapse prevention and limiting the disabling consequences of mental illness require both psychiatric treatment and rehabilitation. Effective integration of treatment and rehabilitation is, therefore, an important preventive component of a community mental health system.

PRIMARY CARE PROFESSIONALS

Many people who seek professional help for mental health problems turn to their primary health care professionals. We believe that it is appropriate for primary health care providers to treat people with relatively minor mental illnesses, such as mild depressions, and that it is unrealistic to believe that enough mental health specialists could be trained and funded in the current environment to pick up the mental health service load carried by primary health care professionals. Research has made it clear, however, that primary care physicians make frequent misdiagnoses and prescription errors. Therefore, we advocate for enhanced training for primary care physicians regarding diagnosis, treatment, and when to refer to a specialist. Such training must be structured in ways that are known to be effective, such as a “detailing” approach. We also advocate for the development of models that integrate mental health professionals into primary care sites and vice-versa.

PRIVATE PRACTICE

By providing low Medicaid rates and requiring excessive paperwork, the public mental health system in New York State has effectively and purposely discouraged clinicians in private practice from playing a significant role in serving people with mental illnesses who need publicly funded services. MHA believes that private practitioners could play an important role in meeting the needs of people served by the public mental health system. Therefore, we support removing

barriers to the use of private practitioners as a component of the public mental health system so long as their participation is subject to responsible quality control.

PROFESSIONAL LICENSING AND SCOPE OF PRACTICE ISSUES

There are a variety of highly charged issues between professional groups such as whether psychologists should be permitted to prescribe medication, whether non-physicians should be able to make diagnoses and sign off on treatment plans, etc. The MHA will not take any positions on guild issues such as these.

However, MHA believes in appropriate licensing of, and reimbursement for, a broad range of mental health professionals, and we will take positions on professional issues that will have a significant impact on access to, and quality of, mental health services.

One example is the social work and mental health licensing law. Under the law, the State “O” Agencies (Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), Office of People with Developmental Disabilities (OPWDD), Office of Children and Family Services (OCFS)) were exempt from meeting licensure requirements until June 1, 2010. The purpose of the exemption was to allow government funded agencies more time to move toward compliance. Since many of these programs rely on social workers to perform services, extension of the exemption was critical to preserving the capacity to provide mental health services in NYS. MHA supported the state’s extension of the exemption for another three years, through 2013 and also the extension of the exemption to include programs overseen by the Office for the Aging (OFA). MHA will monitor the deliverables of the exemption.

PROGRAM DEVELOPMENT APPROVAL PROCESSES

MHA advocates for streamlined approaches to new program development in order to speed up the expansion of community and outpatient services.

PUBLIC ASSISTANCE

People with psychiatric disabilities and children with serious emotional disturbances often depend on public assistance programs to be able to live in the community. From time to time changes in eligibility criteria have resulted in loss of benefits, fueling the growth of homelessness and increasing family burden. MHA will oppose changes in disability criteria that are based on a failure to understand the nature of serious mental illnesses and severe emotional disturbances and their disabling consequences.

QUALITY ASSURANCE

Government Oversight

MHA believes that it is critical that New York State provide careful oversight of mental health programs and other settings, such as adult homes and nursing homes, which house or serve large numbers of people with serious mental illnesses. State oversight should continue to include licensing and critical incident review.

MHA also believes that local mental health authorities have some responsibility for oversight of mental health programs in their communities, whether they are in contract with local government or not. But QA efforts at the Federal, state, and local level should be coordinated and non-duplicative. They should draw from private accreditation processes—such as JCAHO—as much as possible.

In general, MHA supports streamlining licensing and accreditation processes so as to reduce unnecessarily burdensome paperwork.

MHA also supports the effort to shift quality assurance to a primary focus on outcomes rather than on processes and to link the findings of quality assurance reviews to subsequent planning and funding decisions made at the local level.

RECOVERY-ORIENTED SERVICES

MHA supports the current effort to make the mental health system more “recovery-oriented”. This includes helping people with serious mental illness to get jobs, to live independently, to develop meaningful personal relationships, to have access to mainstream recreational, cultural, educational, and religious opportunities.

REINVESTMENT

Children, adults, and older adults with serious mental illness are housed currently not only in state psychiatric centers but also in nursing homes, adult homes, jails, prisons, juvenile detention facilities, residential treatment centers, etc. MHA supports a general strategy of reducing the use of institutional services and reinvesting the savings in the expansion of community-based services, both residential and non-residential. MHA believes that operating savings due to reductions in institutional services should be **fully** reinvested in the expansion of community services. MHA also believes that capital savings and the proceeds of the sale of property now used for state psychiatric facilities and other institutions should be used to support increased housing resources for people with mental illnesses in both specialized and mainstream settings.

In general, MHA supports reinvestment as one, but not the only, measure to increase funding for community behavioral health services.

RESEARCH

Research advances have been the primary source of improved treatment for people with mental illnesses, and research breakthroughs hold the greatest promise for more effective treatment of serious mental illnesses and for enabling people with psychiatric disabilities to live fully satisfying lives in the community.

A Broad Range of Research Initiatives

MHA advocates for a broad range of research initiatives including:

- Biomedical research
- Clinical research regarding effectiveness as well as efficacy
- Services research
- Program and system evaluation
- Epidemiology
- Needs assessment
- The development of disease management models
- The development of relapse prevention techniques
- The development of preventive interventions.

Review Research Agendas

MHA also advocates for OMH to review the research agendas of its institutes with an eye to making them more relevant to the key practice needs and policy priorities of NYS.

Technology Transfer

Even now research is far ahead of the technical mastery of most practitioners. It is critical that the research community do a better job of transferring technology to providers both within and outside academic circles. MHA strongly advocates for greater efforts to transfer available knowledge to the provider community.

Funding for Research and Technology Transfer

MHA supports:

- Continued NYS funding for mental health research and technology transfer
- Expanded Federal funding for research and technology transfer through NIMH, SAMHSA, HRSA, and other federal agencies.

RESTRAINT AND SECLUSION

MHA supports efforts to limit the use of restraint and seclusion only in situations when it is absolutely necessary in order to avoid physical harm to the patient or to others and when it can be used safely. However, MHA will not support approaches that will result in vast increases of paperwork and duplicative reporting requirements.

ROLES OF STATE AND LOCAL GOVERNMENT

MHA believes that both the state and local governments have important roles to play with regard to planning, funding, contracting for, and providing mental health services. Our position is that:

- There should be a balance of state and local planning authority
- There needs to be strong integration between state facilities and local service systems

- Funding should be primarily a state responsibility, but NYS's traditional reliance on local government to share financial responsibility should not be changed rapidly.

SEXUAL OFFENDERS

MHA is opposed to involuntary commitment to psychiatric institutions for preventive detention or for political purposes. They should be used only for people with diagnosed psychiatric conditions who cannot live safely in the community even with extensive supports. Thus, MHA opposes the use of state psychiatric facilities to house sexually violent predators who have completed their prison terms. The solution to this problem should be found in changing sentencing provisions in criminal justice law.

Unfortunately, NYS has enacted civil commitment. Many precautions are being taken to respect civil rights—such as trials to determine the need for commitment—and to protect people with real mental illnesses who live in state psychiatric centers. But MHA remains concerned about the cost of civil commitment and the potential loss of funding for real mental health services as the costs of civil commitment rise exponentially.

STATE FACILITIES

MHA has long been an advocate for caring for people in the community rather than in institutions when at all possible, and we have supported the concomitant reduction of state hospital beds and the increase of community-based services. We believe that, with the development of additional and specialized community services, it may be possible to responsibly reduce the census of state hospitals. However, we believe that such reductions should be carefully planned so as to avoid setting people adrift in the community without adequate supports. Savings from bed reductions should be fully reinvested in community-based services.

Additional savings can be achieved and reinvested in community services by closing additional state facilities even without reducing the census of state hospitals overall. Proceeds from the sale of state land should be used to expand community mental health services, especially housing—using both state and local service programs.

MHA believes that substantial reductions of beds and hospital closures should be subject to thoroughgoing public planning processes, which should attend to issues regarding alternative care, impact on the workforce, impact on training and research, impact on the economy of the local community, use of saved funds and of the land, etc.

Particularly important is the preservation of high quality state programs that are specialized in serving populations who are generally not served outside of the state system.

MHA believes that state inpatient programs have a critical ongoing role as part of the overall mental health system of care. It is important that these programs are of high quality, have adequate staff to patient ratios, and are accessible when needed so as to avoid building up a backlog of patients in local hospitals.

STIGMA AND DISCRIMINATION

Historically, overcoming stigma and discrimination has been a core function of Mental Health Associations. In addition to its own community education efforts, MHA believes that all levels of government should undertake aggressive efforts to combat stigma and discrimination regarding people with mental illnesses. These efforts should include:

- High profile public education campaigns
- Aggressive anti-discrimination efforts
- Aggressive efforts to develop access to housing in the community
- Aggressive efforts to develop access to work
- Aggressive efforts to develop access to mainstream education, recreation, and religious opportunities.

The Americans with Disabilities Act and The Fair Housing Act have both made it possible to combat discrimination to a significant extent. MHA advocates for strict enforcement of these two acts.

SUICIDE PREVENTION

Overall suicide is the 11th leading cause of death. Among young people 15-24 it is one of the 2 or 3 leading causes of death. The rate of suicide increases with age. Adults 65 and older are about 50% more likely than the general population to complete suicide. White men over 85 are at highest risk; they complete suicide at nearly 5 times the average rate. Suicide prevention is, therefore, a critical element of America's public mental health system. MHA advocates for increased efforts to prevent suicide including more research on effective interventions as well as for major initiatives to reduce suicide among adolescents and young adults, among adults with serious mental illnesses, and among older adults.

TAXATION

MHA-NYC does not take positions with regard to increases or decreases of taxes.

UNIVERSAL HEALTH COVERAGE

MHA supports universal health coverage. It is disappointed that the Affordable Care Act stops short of universal coverage, but we support it because it will reduce the number of uninsured from about 50 million to about 16 million by 2014. MHA oppose efforts to repeal the Affordable Care Act or any of its major provisions.

VETERANS, MILITARY PERSONNEL, AND THEIR FAMILIES

Military personnel, veterans, and their families suffer disproportionate rates of mental and substance use disorders and of suicide. To address their problems it is necessary to:

- Expand and improve mental health and substance abuse services provided through the VA and through the generic health, mental health, and substance abuse service systems
- Expand/enhance training efforts for health, mental health, and substance abuse providers
- Develop supportive housing that is accessible to people with disabilities for veterans with mental illness and their families
- Increase mobile case management
- Expand use of peer outreach approaches
- Expand national and state suicide prevention efforts for veterans
- Develop services that address the needs of female veterans
- Develop services that address the needs of family members, including children, of veterans
- Develop mutual aid communities
- Improve collaboration between DVA, OMH, and OASAS
- Improve public education initiatives so that it provides information about mental and substance abuse problems, sources of help for veterans and their families, and info to the general public about the mental health needs of veterans and their families

WORKFORCE DEVELOPMENT

One of the major problems in providing a comprehensive community mental health system is the lack of trained personnel. Two forms of workforce development are needed—(1) training of current personnel in state-of-the-art practices and (2) the development of a larger, trained workforce over time. MHA believes that workforce development should be a high priority nationally and in NYS, especially in light of health care reform.

WORKPLACE MENTAL HEALTH

Workplace policies have a major impact on the mental health of workers and their families. Roughly 60% of Americans have health (and mental health) coverage through work. Virtually all of these mental health insurance plans are managed. Employers often also provide employee assistance programs, and some provide disability management programs as well. Increasingly large employers and insurance companies are instituting disease management programs focused on those illnesses that have the greatest long-term costs. Some organizations have included depression as one of the four or five high priority disorders they typically choose to manage. In addition, as more and more large employers have come to recognize the link between productivity and mental health, they have instituted various efforts to promote mental health through improved working conditions, to identify mental health problems early, and to assure rapid access to high quality treatment. Their perception of the importance of access is leading to changing expectations of managed care organizations—stressing quality treatment in the service of improved productivity rather than mere cost containment.

MHA advocates for workplace mental health policies that contribute to improved mental health. This includes good behavioral health coverage, behavioral managed care emphasizing access to high quality treatment, comprehensive employee assistance programs, disability management to assist people to return to work, efforts to link health and mental health interventions, the inclusion of depression among the illnesses which are the focus of disease management, and organizational arrangements that reduce stress.