



Testimony of
The Coalition of Voluntary
Mental Health Agencies, Inc.
Before the New York City Council

Delivered by
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Mental Health Services and the
New York City Fiscal Year 2001 Budget

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Speaker Vallone, Health Committee Chairman Robles, Chairwoman Clarke, good afternoon. My name is Phillip A. Saperia. I am the Executive Director of The Coalition of Voluntary Mental Health Agencies, Inc. The Coalition is New York City's advocacy organization representing a network of over 100 nonprofit community-based mental health agencies. Taken together, The Coalition's members serve more than half a million clients and deliver the entire continuum of mental health care in practically every community and neighborhood of our very diverse New York City.

Thank you for the opportunity to speak with you today. We depend on the support of our friends and you, both individually and corporately, have been the steadfast friends of community mental health over the years. This year, as in the past, we turn to you for your help.

Unfortunately, an attempt is being made to undo some of the finest work you have done in the last three years. The Executive's January budget modification proposes cutting nearly all the mental health and substance programs that the City Council has added to the budget since 1998, an amount totaling more than \$3 million. These cuts would eliminate a number of programs that provide treatment and services to some of the most vulnerable residents of our City.

Among those slated for evisceration or elimination are: a school-based mental health program in The Bronx, mental health services for Spanish-speaking immigrants in Manhattan, mental health services for Chinese immigrants in Queens, a teen alcoholism prevention program in Staten Island, forensic mental health programs on Rikers Island, alcoholism services for elderly Brooklynites and mental health case management for children involved with the juvenile justice system.

We ask you to restore these short sighted cuts in needed services and programs.

In addition, I would like to focus today on three areas of particular need, children with severe emotional disturbances who are involved with the child welfare system, adults with co-occurring psychiatric and addictive disorders and adults with mental illness who need assistance with housing but are not New York/New York eligible.

1.

Continuity and coordination of care are critical to successful treatment of children with serious emotional disturbances. It is always difficult to integrate all of the disparate support systems in a child's life in order to make that continuity a reality. Educators, physical health care professionals, families and mental health care providers all have to work together over extended periods to ensure that children do not fall through any of the numerous cracks in the system. Families obviously play an extremely important role in serving as a unifying agent that can orchestrate the numerous care elements into a cohesive treatment program.

When a child is in foster care, a difficult task becomes nearly impossible. The insecurity of a foster care family placement causes instability in all of the other elements of a child's life. There ceases to be a single person or unit that can serve as the care coordinator, ensuring communication between the professionals, making sure appointments are kept, assuring medication compliance, providing a single locus for the collection of different types of information. If one were to factor in the additional jolt of frequent moves to new neighborhoods, the possibility is ripe for care to become intermittent and uncoordinated.

While it is estimated that 29-80% of children in foster care have a mental illness serious enough to warrant treatment., most of them remain undiagnosed and untreated. It is self evident, therefore, that emotionally disturbed children in the child welfare system need a 'network of support' that will help them access the numerous systems that they need for support.

For these reasons, we propose the allocation of \$1.5 million to enhance existing children’s community-based mental health programs to enable them to link abused and neglected children to services, build program capacity to serve what has been an underserved population and provide the case management that enables disparate systems to collaborate effectively.

2.

Adults with co-occurring psychiatric and addictive disorders have a similar problem. A co-occurring psychiatric and addictive disorder is just that, co-occurring. When someone is suffering from severe disorders of both kinds, the most effective treatment requires coordinated and integrated treatment under a single program administration. We cannot and must not consider either disorder to be secondary; they must both be concurrently and intensively assessed, diagnosed and treated.¹

People with co-occurring disorders make up a significant portion of the consumer population here in New York City. According to the *1998-2003 New York City Local Government Plan for Adult Mental Health Services* just under 19% of the clients served by City Department of Mental Health programs are Mentally Ill Chemical Abusers (MICA). 83% of these MICA clients are Seriously and Persistently Mentally Ill. 70% of MICA clients are male and nearly one in three males in the City mental health system is a MICA client.

New York has historically taken a lead in addressing this complicated population. Integrated co-occurring disorders treatment interventions and integrated programs

¹Report of The Center for Mental Health Services Managed Care Initiative: Clinical Standards and Workforce Competencies Project, Co-Occurring Mental and Substance Use Disorders Panel. *Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula: Executive Summary*. January, 1998, 5.

designed to adapt to the needs of MICA clients began in 1984 in an outpatient psychiatric facility right here in New York State.² This legacy is something that we should be proud of, and New Yorkers continue to innovate in impressive and exciting ways.

The City Department of Mental Health has created a program at the Cumberland Family Health and Support Center in Fort Greene, Brooklyn that can and should be replicated in every borough and for broad populations. Under a single program administration, mental health, substance abuse, physical health, child care, benefits management and case management have been coordinated for a very difficult to serve group of women. All of the clients in the program are women with open ACS cases who are at risk of losing their children. Not only are services coordinated to a degree not seen elsewhere, but the funding is rich enough to enable the program to treat the whole family, including children, partners and parents. The program has had truly remarkable outcomes, nearly all of the clients are clean and sober, have their psychiatric symptoms under control and have retained custody of their children.

We propose that the City Council allocate \$1.5 million to replicate this enriched, integrated model through community based agencies in the other four boroughs, without the strict eligibility guidelines under which the Cumberland program operates.

3.

The New York/New York agreement is one of the most widely touted mental health care initiatives in our State in recent memory. The City and State have worked together to serve an especially vulnerable population, homeless people with mental illness. The

²Sciacca, Kathleen: "On Co-Occurring Addictive and Mental Disorders: A Brief History of the Origins of Dual Diagnosis Treatment and Program Development." *American Journal of Orthopsychiatry* July, 1996; (66) 3.

results are exceptionally encouraging. Thousands have been helped off of the streets and into supportive environments where they are enabled to rehabilitate their lives and work toward independent living. The New York/New York Agreements, however, have very strict eligibility guidelines. In order to be eligible for this program, a person must both have a diagnosis of severe and persistent mental illness and must have a documented history of homelessness.

An unintended consequence of this policy has been to force people to become homeless in order to access one of the limited beds. People at risk of homelessness, e.g. living with a single elderly parent or in the process of being evicted from an apartment, have been forced to hit rock bottom and end up on the streets before help can be offered them. This is clearly not in the best interests of the clients or the City.

The State legislature recognized the need for housing for people with mental illness who have not descended into homelessness and allocated \$50 million in the fiscal year 2000 budget to provide them with appropriate housing and services. Of this, 80% was earmarked for New York City. This \$40 million, however, required a 1:1 City match. The lateness of the State budget for fiscal year 2000 prevented the City from allocating the necessary capital dollars last year, but we can and should secure the necessary funding this year.

Staff at the Department of Mental Health have worked very diligently to secure \$26 million for this purpose, but a \$14 million shortfall remains. We have an opportunity to bring more State funding to the City and it would be a shame to pass up this opportunity to access State dollars for the benefit of City residents. Therefore **we propose that the City Council allocate \$14 million in capital funding to complete the match of the State funds for housing for people with mental illness who are at risk of homelessness.**

Thank you for the opportunity to speak with you today. I am sure that with the City Council's help we will be able to craft a mental healthcare system in New York City that provides sufficient and appropriate services to will help our residents with mental illnesses remain resident in their communities and live productive and meaningful lives. We appreciate your commitment and your leadership in helping this vision become a reality.