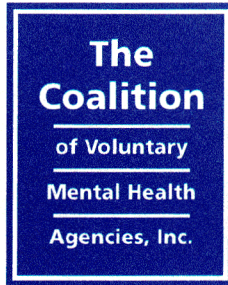


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Community Mental Health Services

New York State Budget Fiscal Year 2002

A Briefing Book

February, 2001

Actions Needed

Passage of *The Community Mental Health Support and Workforce Reinvestment Act* and accompanying Executive Mental Health Budget.

< **Stabilizing the Base of the Community Mental Health System:**

A 2.5% cost of living adjustment for each of the next three years for all mental health budget lines and a 10% Medicaid increase.

Cost to provide services has far outpaced reimbursement to community based agencies which have become the bedrock of the state's mental health system. These agencies must receive funding to repair their financial base in order to stanch the flow of workers from these agencies. Turnover is extremely high and has a serious impact on the continuity of care available to the very people these programs are meant to serve. A COLA and the Medicaid fee increase will fortify the infrastructure and allow for a restoration of the quality of care.

< **An Increase to the Base for Supported Housing** **Up to \$1,080 per bed.**

Since the program began, service has been compromised by rent increases, particularly in New York City, that have far out paced the contract rates. Rents are more than 43% higher than they were in 1990 and salaries are appallingly low. Many providers have begun to subsidize the program from private sources, but are unable to continue doing so. Barring an increase to the base, consumers may be evicted, resulting in serious disruptions in already fragile lives.

< **Supported Employment** **400 new slots**

Work is the most normative activity for people between 18 and 65. As a vital link in the recovery process, employment assistance for people with mentally illnesses makes sense fiscally and programmatically.

< **Medicaid Buy-In.**

New York's adoption of a Medicaid "Buy-in" program would allow people who are already receiving Medicaid to join the workforce, pay taxes and lead more satisfying lives. Don't make people with disabilities choose between work and healthcare—let them have both.

< **The Final Six Months of Reinvestment**

The Community Reinvestment Act of 1993 was a landmark initiative that contributed substantially to the growth and success of innovative community-based programs. These programs have furthered the recovery and independent living of people with psychiatric disabilities.



< **Support and Transition of Shared Staffing Positions**

In many regions throughout New York State, these psychiatrists, nurses, social workers and other professional staff who are shared by the counties and non-profit community sector have been the foundation of services to adults and children with psychiatric disabilities.



Additional actions that require immediate attention:

- < **Expansion of Rehabilitation and Peer-Run Services**
Studies indicate that people with mental illnesses can achieve very high levels of recovery provided they have the necessary support. Self-help and other rehabilitation programs provide just such services, and many are bursting at the seams to accommodate demand. Their vital functions should not be overlooked in this year's budget.
- < **Lifting of the Medicaid Neutrality Cap**
This policy has unfairly restricted the provision of community mental health services for over a decade with no similar cap in effect for Department of Health, Office of Alcoholism and Substance Abuse Services or Office of Mental Retardation and Developmental Disabilities services. Lift the OMH Medicaid cost neutrality provision and spending cap.
- < **Presumptive Medicaid Eligibility.**
Mentally ill individuals returning to the community from stays in jails, prisons or hospitals need immediate access to psychiatric care and medication. End the practice of forcing people coming out of jails, prisons, and inpatient psychiatric facilities to wait 45-90 days for Medicaid eligibility. Provide presumptive Medicaid eligibility for all discharged hospital patients and prison inmates.
- < **Passage of Comprehensive Insurance Parity Legislation**
Mental health parity is a simple matter of equity. Under the current system, people with psychiatric and addictive disorders are discriminated against on the basis of their illness. Thousands of New Yorkers with these disorders are ready to relinquish their federal disability payments and return to work, but they still require adequate mental health insurance coverage which many employee health plans would not cover. Lack of parity has provided a huge disincentive for a return to full employment for people with psychiatric and chemical dependency disorders. Needed: pass comprehensive parity legislation that would require all health plans to provide coverage for mental illness and addictive disorders on the same terms and conditions as any other physical disorder.
- < **Stabilizing and Expanding the System of Care for Individuals with Alcoholism and Substance Abuse Disorders**
Alcoholism and substance abuse is one of our state and nation's leading public health problems, costing many billions of dollars and causing untold suffering in many families and every community. New York State has failed to adequately fund our existing base of alcoholism and substance abuse treatment and prevention programs. A long-term funding mechanism is sorely needed, and would assist the many thousands of addicted offenders and their families who need treatment and prevention services as a result of Rockefeller drug law reform.

Stabilizing the Base of the Community Mental Health System

With the passage of the first Reinvestment Act in 1993, New York State recognized that community based mental health agencies are the bedrock of New York's exemplary mental health



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system. Deinstitutionalization of individuals from State psychiatric facilities sparked a concomitant growth in innovative treatment and services in community settings. The success of new medications and the empowerment of consumers in their own recovery and rehabilitation further lessened our reliance on State psychiatric hospitalization for individuals with serious psychiatric illnesses.

This shift into community systems of care has been largely successful in creating supportive settings for individuals who are recovering from mental illness and has enabled many of them to return to work and lead independent and productive lives. Regrettably, over this same period of time, this community provider sector has been stifled by a reimbursement system that is significantly outpaced by inflation. As a result, the community sector today is precariously placed, even as it is being asked to absorb additional demand for services as well as clients who have more complex needs and require more intensive care.

The most serious erosion has been felt in the therapeutic relationship between clinicians and clients, since reimbursements have not permitted providers to sufficiently pay direct care staff. It is a well documented axiom that the continuity of staff is a vital ingredient in the long-term stability and rehabilitation of mental health consumers. When agency staff turnover is high and frequent, individuals with psychiatric disabilities experience significant disruptions in their progress toward recovery. It is a major failing of the system historically that the retention of quality employees is so impaired by low salaries. In the long run, staff turnover severely hampers the treatment process resulting in frustration to consumers and their families, significant additional cost to providers for recruitment and training, and greater demands on the system and community.

In a statewide survey conducted by The Coalition and the NYS Council, data revealed that most agencies experienced turnover in FY2000, and that the average turnover rate among direct-care staff averaged between 37% and 54%. Anecdotally, one agency reported 100% turnover every eighteen months for entry-level staff. Furthermore, the length of time required to fill vacancies has also grown, further disrupting service to clients. Our salary analysis showed that the lowest level of staff--non-professional, non-supervisory--made an average of \$12.17 per hour, or \$22,150 per year. According to the U.S. government's Current Population Survey for 1999, this is more than \$10,000 per year less than the mean income for the nation.

The providers in the community mental health sector have always been committed to providing the highest quality care in an efficient, cost-effective manner. Unlike other health sectors, however, mental health does not receive an automatic cost of living adjustment (COLA). In order to maintain appropriate levels of service, many agencies have begun to subsidize core mental health services with funds from other sources. This has been a measure taken in desperation, as agencies struggle daily to retain qualified staff, maintain their infrastructures, pay increasing utility and rent costs, and keep up with necessary technology advances to stay viable in a competitive health care marketplace. These additional funding sources are now depleted.

The Legislature has taken incremental steps toward addressing this problem by providing COLAs for various segments of the mental health system in the past several years. The above data shows that this is a systemic problem that will take years of structured increases to improve. The



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Governor takes a significant step in his 2001-02 Budget proposal by providing multi-year funding for a 2.5% COLA and a 10% Medicaid fee increase with his Community Mental Health Support and Workforce Reinvestment Act. We urge the Legislature to pursue the continued reduction in excess bed capacity identified in our state hospitals and to reinvest the savings from this reduction into our community mental health system. Such funding would allow community mental health providers to pay a decent wage to the dedicated workers who have made the commitment to serve those with psychiatric disabilities. Community providers will be better able to retain staff they are losing to private and government jobs, maintain approved facilities and continue to provide the essential levels of care required for the long-term recovery of their recipients of service. Equally important, the COLA proposed for each of the next three years, will allow providers to become more competitive in the marketplace, and to plan programmatic changes based on the predictability of known dollar increases.

The Community Mental Health Support and Workforce Reinvestment Act proposes a 2.5% cost of living adjustment for each of the next three years and a one-time 10% Medicaid fee increase that will bolster the base of the community mental healthcare system so eroded by inflation. The Coalition and the NYS Council strongly support this necessary measure.

Action Requested:

- **Fund \$64 million to support:**
 - **2.5% cost of living adjustment each year for the next three years for eligible community mental health programs**
 - **10% increase for Medicaid-based fees for eligible outpatient programs licensed by the Office of Mental Health**



An Increase to the Base for Supported Housing

At its core, Supported Housing is a simple program that was started in 1990 in order to provide case management services and a rental subsidy for a population that required a wide range of services. The stability this service provides has been critical for people recovering from mental illnesses who want to live in their own communities. Because it was designed to be flexible enough to meet a variety of needs and to provide a continuum of care, it is centered on a case manager who provides assistance in accomplishing day-to-day tasks and coordinates the use of other community resources as they are needed by the client. The rental subsidy, by its very nature, assists in the establishment of a stable living environment for people who could otherwise not afford it.

For several years, providers funded under OMH's contracts have had tremendous success in making available housing opportunities that facilitate choice and maximize independence. In recent years, however, providers have faced skyrocketing rents in an aggressive apartment market. At the same time, virtually no adjustments have been made to funding amounts for these existing apartments. As a result, agencies have been operating their programs with funds that are grossly inadequate to cover costs. Increasing expenses and stagnant funding continue to threaten the effective operation of these beds.

In order to cover costs, providers have drawn upon other sources of income. Many have resorted to use of contingency funds and private resources. In the worst cases, providers have begun to draw upon agency operating reserves. Such "patchwork" funding tactics, however, are only temporary solutions that have run their course. Realistic and ongoing adjustments are needed to ensure the continued provision of effective supported housing to those served by this program.

The cumulative effect of these circumstances is a situation in which the rehabilitation and recovery of consumers is threatened, contravening the program's initial intent—to establish a stable, permanent housing option. Ultimately, the lack of an adjustment will render providers unable to meet landlord's increased rents which will, in turn, decrease consumer confidence in the program. This will likely have a destabilizing effect on those who depend most on its existence. The uncertainty of one's living situation may impair daily functioning and may lead to serious interruptions in the recovery process. In addition, this program provides homes and services to many who were once homeless. A lack of action could result in evictions that would likely play a substantial role in their return to shelters and the street. And most profoundly, the impact of under-funding is the broken promise by the State to bring permanence and stability into lives of fragility and unpredictability.



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For clients the lack of an increase to the Supported Housing base will translate into:

- reduced access to services,
- less frequent contact with case managers,
- increased geographic and psycho-social isolation,
- compromised medication management,

In the absence of any adjustment to this rate by the state, consumers and providers will continue to face rent increases and subsequent evictions. Already there are numerous on-going attempts to evict consumers; still many others have not renewed leases because increases are too high.

The proposal to increase the rate will restore the program's base, rescuing many clients from impending evictions, permitting providers to approve the steep rent increases that are already awaiting their signatures, and allowing consumers to get on with the important work of rebuilding their lives.

Actions Requested:

- **Fund \$5.2 million to support an increase of between \$180 and \$1,080 on the Supported Housing rate for the existing 5,100 beds.**



Supported Employment

One of the primary goals of rehabilitation and treatment for people with mental illness is to support individuals to obtain and retain employment. Employment, after all, is a measure of an individual's recovery and successful re-integration into society. Sadly, only between five and fifteen percent of people with mental illness are involved in the single most normative activity for adults between the ages of 18 and 65: work.

Extended supported employment services offer on-going, post-employment assistance to individuals placed in competitive jobs. By providing these supports, frequently involving visits by a staff person to an individual's job site, individuals with psychiatric disabilities have a greater opportunity to maintain employment. Supported employment slots are therefore a vital element in job retention, employer satisfaction, and client rehabilitation.

Employment provides a measurable and mutual benefit for both the client and the State. People with psychiatric disabilities who are working are more likely to take their medications and less likely to need expensive hospitalization, crisis intervention services and court orders. Furthermore, when people with psychiatric disabilities join the labor force, their status changes from tax users to tax payers. With the potential for an income that rises above simple subsistence levels these clients become greater participants in the economy, and consumers of goods and services.

Actions Needed:

- **Fund \$900,000 to increase by 400 the number of extended support employment slots for persons with psychiatric disabilities.**



Medicaid Buy-In

Recently passed federal legislation sponsored by Sen. Moynihan and Rep. Lazio, the Work Incentives Improvement Act, makes available financial incentives to states that opt to administer a Medicaid "Buy-In" program. New York's adoption of a Medicaid "Buy-in" program would allow people who are already receiving Medicaid to join the workforce, pay taxes and lead more satisfying lives.

As members of the Coalition for a Medicaid Buy-In for New York State, The Coalition and NYS Council support the passage of legislation to allow disabled workers to purchase Medicaid coverage. Currently, disabled New Yorkers who are SSI recipients retain their Medicaid benefits to meet their personal care and/or medication needs when returning to work, under a provision in the Social Security Act called 1619(b). State adoption of the 'Buy-In' program would extend this work incentive to SSDI beneficiaries, who contributed to their disability insurance when they were working.

Furthermore, removing the barriers to work by giving disabled New Yorkers access to health insurance makes good economic sense for New York State's business community. Passage of a Medicaid Buy-In will increase the availability of a workforce whose skills are needed by employers. Employers can take the work opportunity tax credit and the extended credit for working New Yorkers with disabilities who maintain their employment. In addition, if employers pay the health care access premium for a disabled worker, the employer can take the payment as a tax deduction for making an accommodation for a disabled employee. Since taxpayers currently pay for 100% of these benefits when people do not work, providing incentives for people with disabilities to work allows them to contribute by paying taxes; increasing their buying power in the local economy, and by bringing their talents to the workforce.

We call on the Legislature to build upon the Governor's proposal by taking full advantage of the program available to workers under the federal law.



Support and Transition of Shared Staffing Positions

The Coalition and NYS Council support the Governor's 2001-02 State Budget plan for funding and transitioning shared staffing resources to local assistance in the counties where State positions providing those services become vacant. In many regions throughout New York State, these psychiatrists, nurses, social workers and other professional staff who are shared by the counties and non-profit community sector have been the foundation of services to adults and children with psychiatric disabilities. Without shared staffing, many community providers would be forced to severely cut back or close their mental health outpatient and emergency services.

We hope that the Legislature and the Executive will work on a plan to smoothly transition shared staffing into the community when funded by local assistance dollars so that the valuable services they provide to consumers can be maintained for the same purpose in their locality.

Action Requested:

- **Fund \$12 million to support the transition of shared staff positions to local assistance dollars as positions become vacant.**
- **Fund \$3 million in general revenue dollars to cover the fringe benefits attached to those positions.**



Expansion of Rehabilitation and Peer-Run Services

Recent research affirms the profound capacity of people with psychiatric disabilities to achieve substantial levels of recovery, provided they are afforded the proper mix of medical, rehabilitation and support services. The Community Reinvestment Act of 1993, contributed substantially to the growth and success of rehabilitation and peer-run programming which utilized effective new approaches based on the latest advances in recovery, empowerment and self-determination. These services have changed the face of local and state mental health service systems and have driven recent OMH reforms that prioritize employment, education and other meaningful social activities as desired goals for every New Yorker with a psychiatric disability. These programs have furthered the recovery and independent living of people with psychiatric disabilities.

The Coalition and NYS Council support the continued expansion of valuable community-based services that include rehabilitation and peer-run programs. We support the Governor's inclusion of \$6.6 million for new programs in the coming year to fund the final six months of the current Reinvestment Act.

However, the end of this Act must not signal a belief on the part of state government that further growth is not needed or that specific dollars should not be targeted to certain areas of programmatic need. Many existing rehabilitation and peer-run services have waiting lists and simply can't keep up with the great need and strong demand for their innovative, recovery-based approaches. Moreover, many communities continue to struggle to provide an adequate array of these services. For example, despite the large numbers of people in need, New York City has only one peer-run agency.

We therefore urge the Legislature to support the final six months of funding for expanded services under Community Reinvestment, and to assure that additional funds are provided this year and in succeeding years to address critically unmet needs in innovative psychiatric rehabilitation and self-help services that ensure the promise of recovery in our communities.

Action Needed:

- **Fund \$6.6 million to support the final six months of expanded community based programming under the Community Reinvestment Act.**
- **Fund \$3 million for expansion of rehabilitation and self-help services**



Lifting of the Medicaid Neutrality Cap

The Coalition and NYS Council urge the legislature to eliminate the policy of “Medicaid Neutrality” that applies to mental health services only. The cap may be a violation of both State and Federal law. We urge the legislature to eliminate this form of discrimination that prohibits people with mental illness from receiving the services they need, and to which they are entitled.

This policy has unfairly restricted the provision of community mental health services for over a decade with no similar cap in effect for Department of Health, Office of Alcoholism and Substance Abuse Services or Office of Mental Retardation and Developmental Disabilities services. Currently, providers who are transferring, applying for or renewing licenses or who seek to expand services, have to identify the source of the State share of Medicaid funding before the Office of Mental Health will grant the license. The policy further limits the expansion of outpatient mental health services. Some examples are as follows:

- Agencies cannot expand their clinics into evening hours to serve individuals in need of treatment who are working, including the working poor.
- New services for under-served populations, such as HIV infected and the fragile elderly, are proscribed.
- While the demand for school-based mental health clinics is very high, the neutrality cap prevents new clinics from operating.
- Under-served communities are effectively prevented from receiving local services.

Essentially, the Medicaid Neutrality Cap prevents providers from meeting community need as identified by the State Office of Mental Health.

Action Requested:

- **The OMH Medicaid cost neutrality provision and spending cap must be lifted.**



Presumptive Medicaid Eligibility

Mentally ill individuals returning to the community from stays in jails, prisons or hospitals need immediate access to psychiatric care and medication. In order to transition from these settings back into the community, they must have access to medication, case management, treatment services and appropriate housing. Immediate access to these services is the best way to guarantee a safe return to the community for this population.

Most hospitals give patients a two-week supply of medication upon discharge, but beyond that, the patient must rely on a patchwork of community agencies and his/her own ability to negotiate the system to obtain medication and services without insurance coverage. The situation is worse for mentally ill prisoners leaving prison and jail—even if they can access the medication program under Kendra's Law. Even with care coordinators, the treatment that is a necessary corollary to medication cannot be paid for. These folks are left to the mercy of public or private programs already operating at capacity, or more likely, are left to fall between the cracks. Without immediate access to Medicaid insurance even good discharge plans fail, leading to a senseless waste of human potential and money: a revolving door of homelessness, hospitalization, incarceration and tragedy.

An individual discharged into the community without Medicaid must take it upon him/herself to apply for Medicaid, most often without the help of hospital, jail or prison staff. It takes between 45 and 90 days for the Department of Social Services to determine eligibility according to State Social Service law. This means that if an individual applies for Medicaid on the day s/he enters the community, at best Medicaid eligibility will be granted in a month and a half. Presumptive eligibility would eliminate the waiting period that occurs while Medicaid eligibility is verified by local Social Services district staff and replaces it with a 90 day assumed eligibility period.

It is essential to note that the federal Department of Health and Human Services has ruled that prisoners do not have to have their Medicaid eligibility cancelled. Instead, it could be suspended for the duration of the prison stay and instantly reinstated upon discharge. The current system is State directed.

Presumptive Medicaid eligibility is far superior to the medication grants under Kendra's Law. Medication is not treatment. Providing a person with pills is an ineffective way to treat a serious mental illness. It is safer and more comprehensive and efficient to allow access to all Medicaid services for this population than to guarantee access to medication, but not any other Medicaid treatment.

Additionally, presumptive eligibility maximizes the impact of the State's dollars. The medication management program relies entirely on State funds, while presumptive eligibility will draw down Federal subsidies. Furthermore, the medication grant program will be implemented on a county-by-county basis. Consumers in counties that choose not to participate will be excluded from the program. In order to participate, counties will need to set up an entirely new layer of bureaucracy, drawing scarce resources away from the consumers who need them.



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Moreover, once a determination of eligibility is made Medicaid will reimburse for services up to 3½ months prior to the date of initial application. This means that for consumers who are ultimately deemed eligible, no general fund dollars will be necessary. The provision of presumptive eligibility will maximize the benefit of State dollars to people with mental illness and provide the continuity of care that they so desperately need.



Passage of Comprehensive Insurance Parity Legislation

While significant strides continue to be made against discrimination of all kinds throughout the nation, many myths and misunderstandings persist, particularly for people with psychiatric disabilities. Despite the fact that diagnosis and treatment of psychiatric and addictive disorders have undergone dramatic improvements in recent years, health plans in New York State continue to deny persons living with these illnesses access to services that would benefit them. Immediate steps must be taken to end the disparity between insurance coverage provided for physical illness and those that are provided for mental illness and chemical dependency. Ending this discrimination will provide access to treatment and services that would help these individuals to attain healthy and productive lives—and may make a contribution to the reduction of the pervasive stigma that is associated with mental illness.

We seek the passage of comprehensive parity legislation that would require all health plans to provide coverage for mental illness and addictive disorders on the same terms and conditions as any other physical disorder. Such coverage must include:

- equitable access to benefits and covered services that apply to all cost-sharing requirements and financial components equally for both psychiatric, chemical dependency and general medical conditions
- lifetime or annual payment limits, deductibles, co-payments, co-insurance, out-of-pocket limits, visit or day limits that do not place a greater financial burden or are not more restrictive on a person treated for a psychiatric or chemical dependency disorder than those requirements or limitations for general medical conditions.
- health plans that are not allowed to limit arbitrarily individual access to necessary mental health or chemical dependency services through unnecessary coverage limitations, unwarranted utilization review controls or exorbitant cost-sharing requirements.

In addition, The Coalition and NYS Council support insurance parity legislation because the thousands of New Yorkers with psychiatric disabilities and chemical dependency disorders who are ready to relinquish their federal disability payments and Medicaid to return to work must be able to rely on adequate mental health insurance coverage in their employee health plans. Lack of parity has provided a huge disincentive for a return to full employment for people with psychiatric and chemical dependency disorders.

New York must join the other 32 states that have enacted insurance parity legislation. We urge the Legislature to pass comprehensive behavioral health parity legislation this year, ending years of discrimination, saving taxpayers money and enabling thousands to return to the mainstream.



Stabilizing and Expanding the System of Care for Individuals with Alcoholism and Substance Abuse Disorders

As providers of behavioral health care, our members provide treatment to clients with co-occurring psychiatric and addictive disorders, and to clients with alcoholism and substance abuse in our programs licensed under OASAS. Year after year, we are disappointed and puzzled by the lack of investment in our chemical dependency system, which has suffered from the same infrastructure problems as the mental health system.

While the mental health system will receive an increase of over \$112 million under the Governor's proposed 2001-02 plan, there is no recommended increase at all for the alcoholism and substance abuse system. Given the Governor's recently announced plan to reform the Rockefeller Drug Laws, it is alarming to see no complimentary proposal for supporting and expanding community treatment for the non-violent offenders who are likely to move into treatment under such reform.

Alcoholism and substance abuse is one of our state and nation's leading public health problems, costing many billions of dollars and causing untold suffering in many families and every community. Recent studies by the New York State Office of Alcoholism and Substance Abuse Services and other leading researchers have documented the dramatic successes of treatment and prevention in reducing not just alcohol and drug dependence and abuse, but also some of their social and health consequences.

Yet New York State has failed to adequately fund our existing base of alcoholism and substance abuse treatment and prevention programs. Like the mental health sector, the chemical dependency system suffers the same high staff turnover rates, crumbling infrastructures and the inability to fund new and innovative programs since reimbursement has not keeping pace with inflation. We ask the Legislature to provide an immediate increase to OASAS to strengthen existing services. This would include funding for a cost of living adjustment, and for infrastructure and technology improvements.

Further, The Coalition and NYS Council urge the Legislature to consider "Drug Law Reform Reinvestment" which would provide a long-term funding mechanism in the addictions field which has been sorely needed, and would assist the many thousands of addicted offenders and their families who will need treatment and prevention services as a result of Rockefeller drug law reform. Modeled after the Community Mental Health Reinvestment Act of 1993, savings created by reform of the Rockefeller drug laws would be reinvested in prevention, treatment, job training and other essential community support services.

The Community Reinvestment Act of 1993 was designed to move funds from outdated, underutilized state hospitals into local community care, and dramatically increased the involvement of consumers in their own treatment and recovery. Over seven years, Reinvestment has provided over \$175 million into the system, has resulted in over a thousand new innovative treatment programs for individuals with psychiatric illness, and has been nationally recognized for



its success in creating a safety net in our communities as people are moved out of institutional settings.

Drug Law Reform Reinvestment will address all these issues by providing the resources necessary to shore up the existing foundation of our alcoholism and substance abuse treatment and prevention system as well as develop the necessary capacity to provide services to the thousands of people diverted from prison every year by sentencing reform.

Successful outcomes from the treatment of alcoholism and substance abuse are to be expected if the addicted individual receives the appropriate level of care for the proper duration of time and with the necessary aftercare. The single greatest predictor of treatment success is length of stay in treatment. OASAS outcomes data demonstrate dramatic decreases in problem behaviors after six months in treatment. Drug and alcohol use decreases dramatically as does use of expensive healthcare (ER, inpatient hospital stay), arrests, incarceration, child abuse and neglect, domestic violence, and other undesirable behaviors. Employment increases, dependency on public assistance decreases, and quality of life improve after six months or more of treatment.

Providing OASAS licensed, community-based treatment as an alternative to incarceration or at the point of re-entry into the community after a period of incarceration will result in significantly lower rates of crime and recidivism. Community-based treatment is the key to successful drug law reform. Treatment in the criminal justice system is important and **must** be followed with treatment in the community. Studies show that recidivism will be almost as great for persons who received treatment in prison as those who did not if community-based treatment is not provided upon release.

OASAS licensed community-based treatment is essential for public safety and public health. Releasing inmates or diverting arrestees without a strong treatment component poses considerable public risk. Community-based treatment provides a therapeutic structure that dramatically increases the likelihood that a person will remain drug/alcohol free and become a law abiding, productive citizen.

Reinvestment is the best way to fund a major initiative to make treatment the first option in addressing behaviors related to addiction. The experience of the mental health field and the lessons learned about the best way to implement reinvestment should inform the development of Drug Law Reform Reinvestment.

Actions Requested:

- **Support an immediate infusion of funds to cover a cost of living adjustment and technology enhancements to keep pace with advances and online program reporting requirements;**
- **Support a drug law reform reinvestment initiative that would reinvest the savings from the reform of the Rockefeller drug laws into the community treatment and prevention system.**



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Educational Alliance
F.E.G.S.
The Floating Hospital
Fordham-Tremont CMHC
Fountain House
F.R.I.E.N.D.S.
Goddard Riverside
Graham-Windam Services
H.I.R.E.
Hamilton-Madison House
Harlem-Dowling Westside Center
Henry Street Settlement
Hudson Guild
Institute for Community Living
International Center for the Disabled
Jewish Association of Services for the Aged
Jewish Board of Family & Children's
Services
Jewish Child Care Association
Jewish Guild for the Blind
John Heuss House
Joseph P. Addabbo Family Health Center,
Inc.
Karen Horney Clinic, Inc.
League Treatment Center
Lenox Hill Neighborhood Association
Lexington Center for Mental Health Services
Lifeline Center for Child Development
Lower East Side Service Center
Lutheran Medical Center-MH Clinic
Mental Health Providers of Western Queens
Metropolitan Center for Mental Health
Montefiore Medical Center
Mount Sinai Medical Center
Neighborhood Care Team
New York Psychotherapy & Counseling
Center
New York Service Program for Older People
New York Society for the Deaf
Northside Center for Child Development
OHEL Children's Home & Family Services
Partnership for the Homeless
Paul J. Cooper Center for Human Services
Pesach Tikvah - Door of Hope
Project Hospitality
Project for Psychiatric Outreach to the
Homeless
Project Renewal
PSCH
Puerto Rican Family Institute
Queens Child Guidance Center
Riverdale Mental Health Association
Safe Horizon
Safe Space
Samuel Field YM-YWHA CAPE
Services for the Underserved
Sky Light Center
Spanish Speaking Elderly Council-RAICES
St. Francis Friends of the Poor
St. John's Episcopal Hospital Center
St. Vincent's Services
Staten Island Mental Health Society, Inc.



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Steinway Child & Family Services, Inc.
The Bridge, Inc.
Union Settlement Association
University Consultation & Treatment Center
University Settlement House
Upper Manhattan Mental Health Center, Inc.
Urban Pathways

Venture House
Visiting Nurse Services of New York
Volunteers of America-Greater New York
Weston United Community Renewal, Inc.
William F. Ryan CMHC
Women In Need



New York State Council 2001 Member Agencies

Bedford-Stuyvesant CMHC
Bronx-Lebanon Hospital Center
Brookdale Hospital CMHC
Cayuga Counseling Services, Inc.
Cayuga County CMHC
Central Nassau Guidance & Counseling Center
Central New York Services
Child & Adolescent Treatment Services
Child & Family Services
Clifton Springs Hospital & Clinic
CMHC of Glens Falls Hospital
Crestwood Children's Center
The Dale Association
Dutchess County Department of Mental Hygiene
Family & Children's Service of Niagara, Inc.
Fordham-Tremont CMHC
Horizon Health Services, Inc.
Human Technologies Corporation
Kaleida Health
Lake Shore Behavioral Health
Lewis County CMHC
Maimonides Medical Center CMHC
Mental Health Association in Albany
Mercy Medical Center Behavioral Healthcare Services
Mid-Erie Health Services
Multi-County Community Development Corporation
Niagara Falls Memorial Hospital
CMHC/Health Systems Niagara

North Star Behavioral Health Services
North Suffolk Center
Northern New York Center
Northwest CMHC
Occupations, Inc.
Pederson-Krag Center, Inc.
Putnam Hospital Center
Rehabilitation Support Services, Inc.
Sound View-Throgs Neck CMHC
South Bronx Mental Health Council
Southeast Nassau Guidance Center, Inc.
Spectrum Human Services
St. John's Episcopal, South Shore CMHC
St. Joseph's Hospital CMHC
St. Mary's Hospital CMHC
St. Vincent's Hospital and Medical Center
St. Vincent's-North Richmond CMHC
Staten Island Mental Health Society, Inc.
Steuben County CMHC
Sunrise Psychiatric Clinic
Transitional Living Services of Onondaga County, Inc.
United Health Services Hospitals
Unity Health System Park Ridge Mental Health Center
Unity Health System St. Mary's Mental Health Center
University of Rochester CMHC
VIAHEALTH The Genesee Hospital
VIAHEALTH Rochester Mental Health Center