Statement

Of

THE NATIONAL ALLIANCE ON MENTAL ILLNESS
OF NEW YORK STATE (NAMI-NYS)
MICHAEL SILVERBERG, PRESIDENT

Before

THE PUBLIC HEARING ON
THE NEW YORK STATE OFFICE OF MENTAL HEALTH'S
2006-2010 COMPREHENSIVE PLAN FOR MENTAL HEALTH SERVICES

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My name is J. David Seay, and I am the Executive Director of the National Alliance on Mental Illness of New York State (NAMI-NYS), New York's voice on mental illness. NAMI-New York State represents 58 affiliate organizations with thousands of members across New York State. NAMI has nearly a quarter million members nationwide. Our mission is to improve the lives of all who are affected by serious mental illness.

This year's Statewide Comprehensive Plan for the Office of Mental Health is meant to be read in the context of the strategic plan framework laid out by the 2005 statewide plan. Accordingly, we would like to incorporate by reference our testimony on the 2005 plan, a copy of which is appended.

There is important news in this plan, including a presentation for the greater part of two chapters on the "Balanced Scorecard," which is described as "a dynamic, continual and comprehensive strategic performance management system that encompasses mission, strategy and perspective" as well as "a web-based platform for providing accurate and up-to-date information for monitoring progress toward achieving the agency's aims, goals and objectives."

As a tool for transformation, the Balanced Scorecard has tremendous potential, but it can only be realized when the right questions are asked, not only of the state facilities, but the 2,500 or so programs that OMH has certified as well. Not only that, but the needs of the 790,000 New Yorkers who are estimated by the U.S. Census Bureau to need mental health services must eventually be accounted for.

One of the strategic priorities of this year's plan is to provide access to safe and affordable community housing. For the balanced scorecard to measure whether sufficient access to housing is being provided, OMH will have to maintain an accurate statewide waiting list for mental health housing and/or conduct a thorough statewide housing needs assessment locality by locality, something for which we've advocated for years.

Currently, there is a large gap between how services are actually performed and how they are performed on paper. The crucial question in regard to the Balanced Scorecard is whether it will narrow that gap -- whether it will lead to a breakthrough in performance management or merely to the status quo.

Ultimately, the answer to that question won't be determined by the Balanced Scorecard, however. The Balanced Scorecard is a tool for oversight. It cannot create housing, for example. It cannot bring evidence-based prescribing practices to community clinics serving hundreds of patients with a lone psychiatrist. Or integrate evidenced-based treatment for co-occurring disorders into continuing day treatment programs that rely on newly minted clinicians with overwhelming caseloads, due to their inability to adequately pay and retain seasoned professionals. Or spur the provider with an ingrained bias against collaborating with families to offer family services and change its organizational culture.

However, given these challenges, the Balanced Scorecard can be a tremendous help in maintaining and improving our mental health care. The creation of a publicly accessible performance management system is should be very positive step going forward. This is good news.

Other good news is that "D" has now been added to OMH's "ABCs," for "disparities elimination and cultural competence." This has been a priority for NAMI

Bronx and NAMI Metro member Sigfrido Benitez and several other members of NAMI. We can no longer ignore the barriers to appropriate care that confront persons from different ethnic and language groups. Integrating effective ways to accomplish multicultural inclusion is a task that must be accomplished throughout the mental health community. We are delighted that OMH has made disparities elimination a priority.

We would like to acknowledge the mental health initiatives in the Executive Budget, with which the plan's development has been coordinated. These include a Cost of Living Adjustment for providers of community services, increased funding for supported housing, the New York/New York III agreement, the suicide prevention initiative, and the single largest investment in children's services in New York's history.

We truly appreciate these initiatives, especially those that promote more housing, which is our number one priority. Among the initiatives is the funding of the Geriatric Mental Health Act, which will provide demonstration grants through a Geriatric Mental Health Council. We wholeheartedly support these timely efforts to address the needs of our older New Yorkers with psychiatric disabilities.

Of concern to us in the plan is a statement related to the Commission on Health Care Facilities in the 21st Century, which is responsible for "right-sizing" hospitals and nursing homes. According to the plan, OMH is assessing the future inpatient capacity needs of state psychiatric hospitals before making any new closures or reductions in beds. The plan goes on to say that any such actions will take place in collaboration with the Commission on Health Care Facilities. Does this mean that the closing of state hospitals is in the purview of this commission? What is OMH doing to represent the interests of the mental health community to the Commission?

It has been our understanding that the Commission was looking at Article 28 community hospitals, not Article 31 state hospitals. This alone is of tremendous concern, because if the commission does not take into account the value of the psychiatric acute care wards in community hospitals, it could produce an unprecedented crisis around the state. The acute care wards provide the principal means for treating persons who are in crisis, providing them with the stability to benefit from outpatient services. Altogether, they provide 65 percent of the inpatient care in New York State. In many localities, community hospitals provide outpatient services as well. The entire mental health system depends upon these facilities.

An observation we would like to make about this plan is that nowhere does it address family services, although NAMI New York State is now collaborating with OMH, and the Family Institute and Rochester on a major initiative to bring a spectrum of family services to providers throughout the state. In fact, the only references we can find to families are as parts of a conjunction: phrases such as "consumer and family-driven," for example, or "children and families."

To quote the NAMI New York State White Paper, *Helping Families to Help Their Loved Ones*, which was recently approved by our board: "Persons who have a serious mental illness deserve and often require family help. Families can and do play a life-or-death role, and often a primary role in important improvements in their loved ones' lives. Constructive family involvement greatly multiplies the odds that the loved one will get better."

The white paper goes on to discuss what families do for their ill loved ones and the kinds of services that would make them most effective. These consist of

collaboration, education and support. We know that OMH is committed to establishing a program of integrated family services, and we hope its efforts to do this will be prominently featured in next year's plan. As the white paper concludes, helping families to help their loved ones may be our most promising avenue of progress.

Regarding the plan's "strategic priority" of confining violent sexual predators, we would like to preface our remarks by expressing our gratitude to the state that it intends to keep sexual predators separate from patients in psychiatric hospitals, to keep the funding stream for civil confinement separate from, and in addition to, the regular OMH budget, and to add beds for the predators rather than take away existing beds meant for persons with a severe mental illness such as schizophrenia, bipolar disorder and clinical depression.

We thank the state in advance for taking these steps. They are necessary steps. However, they are not sufficient to prevent great harm to the mental health system. In order to do that, violent sexual predators must not only be kept physically separate from mental health care consumers, but *conceptually* separate as well.

We would like to take a few moments to explain our position.

Medically, there is no such thing as a "violent sexual predator disorder." There are bills before the legislature, however, that would create such a malady through political fiat, not scientific consensus.

It is our understanding that most violent sexual predators coming out of prison – and for that matter, the majority of prisoners no matter what the crime – are diagnosable for Anti-Social Personality Disorder, a DSM Axis II diagnosis. It is also our understanding that individuals with an Axis II diagnosis don't qualify for most OMH-funded mental health services unless they have an accompanying Axis I diagnosis.

Violent Sexual Predators have two common denominators: They have a sexual deviancy, and they also are very dangerous. It is this threat of doing harm to others that is the critical factor. Without that threat, it is unlikely that anyone would go through the trouble to change the law so that they can be confined indefinitely in state facilities.

The threat is very real. The trauma of sexual abuse can cause long-term damage to the mental health of their victims and long-term problems for families and communities. Just ask any of the large number of consumers who have been sexually victimized what it has done to them. It is the severity of this threat that has caused the state to want to treat the Anti-Social Personality Disorders of violent sexual predators as an Axis I diagnosis.

The severity of a threat and the severity of an illness are two different things, however. Violent sexual predators are not ill as much as they are pathogenic. It may be a legitimate argument that they should be quarantined as part of a public mental health effort, but it is not legitimate to say that they should be put in the same category as people with a serious mental illness like schizophrenia, bipolar disorder or clinical depression.

This distinction is tremendously important if we are to have any chance of preserving the integrity of our system of mental health care, and so far, it simply hasn't been made. Conceptually, the victimizers have been mixed up with the victimized. The comprehensive plan states that civil confinement supports the goals of "continuous quality improvement" and "access to services," for example. "Aligning" these goals with the "strategic priority" of civil confinement is quite a reach, to put it mildly. Bending the plan's strategic framework around like this to justify the incarceration of dangerous

sexual deviants creates serious concerns about the plan's creditability. Why? Because it implies that these people are consumers, up-ending all the assertions about a consumer- and family-driven, recovery-oriented service system. Are these people going to be in the driver's seat of their course of "treatment"? Are they going to be represented on the Recipient Affairs Committee? Are they going to be occupying mental health housing beds? We sure hope not. Sexual predators are not consumers in any common use of the term.

We believe that a Department of Corrections or OASAS facility would be a more appropriate place to put individuals with this criminal disorder, which can be described as a form of compulsion or addiction. Other states have done so. However, if the state is going to go through with civil confinement under the auspices of OMH, it must keep consumers and predators separate in word as well as deed. We cannot afford them to be lumped together in the public mind, which would defeat the strategic plan's aim "to promote community integration and acceptance through the reduction of stigma," or to be dishonest with ourselves about why they are in the system.

In conclusion, this year's Statewide Comprehensive Plan has elements that are promising -- such as the balanced scorecard and the heightened priority for disparities elimination and multicultural inclusion -- and upsetting, such as the civil confinement of sexual predators in the mental health system. How it will turn out is up to those who carry it out, working with what they have. It will be up to all of us, whether the promises or the concerns will be realized and whether things will get better or worse.