Broken Promises, Broken Dreams: A Report on the Status of the Mental Health Delivery System in New York State

October 2002

A Report by the New York State Assembly Standing Committee on Mental Health, Mental Retardation and Developmental Disabilities

EXECUTIVE SUMMARY

The people of the State of New York have historically supported policies designed to improve the lives of persons suffering from mental illnesses or who were otherwise mentally disabled. The State Constitution, the Mental Hygiene Law and related statutes provide expression to that support and form a framework for the development and implementation of an effective system of service delivery.

In February 2001, the New York State Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities initiated a comprehensive review of the status of the mental health service delivery system. The impetus for this review was the Governor's proposal in early 2001 to close two State operated psychiatric centers and relocate State operated children's psychiatric centers onto the grounds of adult psychiatric centers in order to provide cost of living adjustments (COLAs) and Medicaid rate increases to certain community based mental health service providers.

NEW YORK STATE CONSTITUTION

ARTICLE IV, SECTION 3: The governor shall….expedite all such measures as may be resolved upon by the legislature, and shall take care that the laws are faithfully executed.

ARTICLE XVII, SECTION 4: The care and treatment of persons suffering from mental disorder or defect and the protection of the mental health of the inhabitants of the state may be provided by state and local authorities and in such manner as the legislature may from time to time determine (approved by a vote of the people November 8, 1938).

MENTAL HYGIENE LAW

Section 1.01 (Ch. 978 of the Laws of 1977)

> Protecting the mental health of the people of the state, preventing the occurrence of mental illness, mental retardation and developmental disabilities, alcoholism and substance abuse and assuring that state residents afflicted by such disabilities receive appropriate care and treatment are matters of public concern.
>
> It is the policy of the state of New York that all of its residents who are disabled will receive services according to their individualized needs and, whenever possible, in their home communities to enable them to realize their fullest potential for self-fulfillment and independent living in society.

The Governor, as Chief Executive of the State, sets the tone for his administration. The Governor has a constitutional responsibility to faithfully execute the laws of the State of New York and to expedite implementation of laws enacted by the Legislature. In October 2002, Governor George Pataki publicly stated:

> "I'm proud that no administration has come close to doing what we've done to help the mentally ill adults in New York State."

However, over the past seven years, Governor George Pataki has:

- Ignored the statutory planning and reporting requirements of the law regarding the mentally ill, resulting in a disjointed, top down planning process that is inefficient, facilitated wasteful use of public resources, and hindered the ability of the Legislature to focus the use of public resources to meet the needs of the mentally disabled.

- Disregarded the discharge planning requirements of the law enacted to ensure that mentally ill individuals released from state operated facilities are provided stable housing and support services consistent with their needs.

- Removed hundreds of millions of dollars earmarked by the Legislature to improve the mental health system statewide pursuant to the Mental Health Community Reinvestment Act.

- Allowed the Community Reinvestment Act to expire in 2001 and removed another $62 million from the mental health service system during the current fiscal year.

- Failed to sign a renewal of the Community Reinvestment Act passed by the Legislature in June 2002.

- Ignored the reporting requirements of the Social Services Law, leaving the public and the Legislature in the dark regarding abuses of the mentally ill in adult and nursing homes.

- Emasculated the oversight and enforcement arm of his administration responsible for adult homes.

- Hindered development of enriched services programs for chronically mentally ill persons residing in adult homes.

The failure of the Governor to faithfully execute the laws of the State of New York and to expeditiously implement the laws approved by the Legislature created a public health crisis and is a violation of the public trust. Promises made by the people of this State in the Constitution and through their elected representatives in the Legislature to help the mentally disabled have been broken. The failure of the Governor to comply with the planning and reporting requirements of the Mental Hygiene Law and the removal of significant public resources from the mental health system by the Governor has severely limited the ability of the State to develop alternative residential and service delivery programs for mentally ill persons in their home communities. As a result, thousands of mentally ill persons have suffered indignities and abuse, and hundreds of others have succumbed to untimely deaths due to a dysfunctional mental health system.

The Legislature needs to take immediate steps to re-establish the public trust by:

- Restructuring the Department of Mental Hygiene to better enable it to meet its statutory mission.

- Strengthening the planning requirements of the Mental Hygiene Law to ensure a community directed and focused system of service delivery based on individual needs and the most effective use of available resources.

- Ensuring that discharge planning statutes are implemented as intended.

- Implementing short and long-term responses to the housing crisis facing our most vulnerable residents consistent with the Olmstead Act.

- Establishing simplified funding mechanisms, including the use of blended funding, to more effectively and efficiently meet the needs of the mentally disabled in their communities.

The NYS Assembly has already passed legislation to begin the restructuring of the Department of Mental Hygiene and to strengthen the planning requirements of the Mental Hygiene Law. Together, the Assembly and the Senate passed legislation to reconfirm the policy of reinvesting savings from the downsizing of the State operated mental health system into communities across the State. In addition, the Assembly has taken steps to exercise its constitutional oversight responsibilities and to reiterate its longstanding commitment to improve conditions in adult homes by introducing legislation to address the crisis in the adult homes industry. Over the next several months, the Assembly will develop additional responses, requiring cooperation by the Senate and the Governor, to help ensure that the promises to the mentally disabled, made by the people of the State of New York, are kept.

DEPARTMENT OF MENTAL HYGIENE

Chapter 978 of the laws of 1977 was enacted, effective April 1, 1978, establishing three separate Offices and an Inter-Office Coordinating Council (IOCC) within the Department of Mental Hygiene (DMH). It was determined by former Governor Carey and the Legislature that three separate Offices would be better able to focus on the needs of the mentally disabled within their purview than a Department that had a bias towards the needs of the mentally ill. The IOCC was created to help ensure that the Offices worked cooperatively to meet the needs of the multiply disabled and to better utilize and share resources for greater efficiency of operations. Simultaneously, the Commission on Quality of Care for the Mentally Disabled (CQC) was established to provide an independent review of the operations of the Offices within DMH. Over time, the IOCC was stripped of its resources and each Office essentially acted independent of one another. Consequently, efforts to address the needs of the multiply disabled were intermittent, fragmented and dependent on the interests and priorities of the leadership of each Office.

Statewide Planning for the Mentally Disabled

Section 5.07 of the Mental Hygiene Law was enacted, as part of the 1977 reorganization of the DMH, to provide a blueprint for the establishment of statewide goals and objectives and comprehensive plans of services for the mentally disabled. The Legislature's purpose in enacting this statute was twofold: (1) to ensure that planning to meet the needs of mentally disabled persons, including the multiply disabled, would be an open visible process, and (2) to assist the Legislature in establishing funding priorities and program initiatives to best facilitate

the ability of the mentally disabled to live their lives in dignity and, whenever possible, in their home communities.

The Legislature intended that this annual, bottom up planning process would reflect a partnership between State and local governmental units, and emphasize how gaps in services would be filled. Advisory Councils were created for each of the Offices to establish measurable statewide goals and objectives, to be reviewed on an annual basis by a process that was open, visible and accessible to the public. The Offices within DMH were then to formulate comprehensive five-year plans with annual updates. These plans were to be formulated from local comprehensive plans developed by each local government, with participation from individual consumers, consumer advocacy groups, service providers and Department facilities. Section 5.07 specified, at a minimum, the information that was to be included in the annual plans. (See Appendix 1) These plans were to be completed and due on October 1st of each year with copies to the Legislature. This action was taken to establish a process whereby the plans could be considered by the Governor and the Legislature prior to the next Executive budget.

In addition, an interim report, detailing each Commissioner's actions in fulfilling the requirements of Section 5.07, including modifications being considered, was to be submitted to the Governor and Legislature no later that February 15th of each year. These reports were to also assist the Governor and Legislature in establishing programs and policies for the ensuing fiscal year.

Section 5.07 further requires each Office to prepare a three-year capital plan with annual updates that correspond to the statewide five-year plans. The Advisory Councils are to review these plans and make recommendations. Copies of this plan, as well as the recommendations, are to be submitted to the Legislature on October 1st of each year.

Despite the mandates set forth by Section 5.07, for the past seven years, Governor Pataki has ignored the planning requirements of the Mental Hygiene Law. The last statewide comprehensive plan submitted pursuant to the requirements of the law was in 1994. In 1997 and again in 2001, the Office of Mental Health (OMH) submitted planning documents that did not conform to the requirements of the law. As a result, local governments, service providers, advocates and consumers have not been able to plan for the provision of mental health services based upon locally identified needs. The consequence has been a disjointed, top down planning process that is inefficient, facilitating wasteful use of public resources, and contrary to the intent of the legislation. This absence of Executive leadership has also hindered the Legislature's ability to establish policies and funding priorities consistent with the needs identified by local governments and other stakeholders.

In May 2001, OMH submitted a report to the Legislature, entitled "Statewide Comprehensive Plan for Mental Health Services 2001-2005." Although the Executive Summary of this report states, "This plan has been developed in accordance with Mental Hygiene Law, Section 5.07…" following review of the document, Assemblyman Martin A. Luster, Chairman of the Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities Committee, informed OMH Commissioner, James Stone, that the comprehensive plan was <u>not</u> prepared in compliance with the requirements of Section 5.07. More specifically, in correspondence forwarded by Chairman Luster to Commissioner Stone on June 28, 2001, the Chairman stated, in part (see Appendix 2 for full text):

"This letter is a follow up to our meeting on June 21st. At that meeting I discussed with you the statutory reporting requirements of Section 5.07 of the Mental Hygiene Law. I informed you that the document entitled, Statewide Comprehensive Plan for Mental Health Services 2001-2005…while providing useful information, did not meet the Section 5.07 reporting requirements. Section 5.07(b)(1)…states that, "Each plan shall be formulated from local comprehensive plans developed by each local government, with participation of consumers, consumer groups, providers of services and departmental facilities furnishing services to the mentally disabled of the area in conformance with statewide goals and objectives established by the advisory council of each office." Section 5.07(b)(2)i….states, "to the extent practicable, all such information required pursuant to this paragraph shall be provided on a statewide, regional and individual state-operated hospital and state-operated research institute basis."

"A delineation of the goals and objectives of the Advisory Council was not included in the OMH 2001-2005 planing document. There is no statement or other evidence in the planning document that it was formulated from local comprehensive plans developed by each local government. In addition, the planning document did not break down required information by region or individual hospital basis…..

"The NYS Assembly looks forward to working with the Office of Mental Health when it is in compliance with the statutory reporting requirements of the Mental Hygiene Law. While the Office of Mental Health works to establish credibility with the Legislature, please provide the Assembly Mental Health Committee with the following…information at your earliest convenience.

- A list of members of the Mental Health Services and Advisory Councils, including addresses and phone numbers.

- The most recent Statewide Goals and Objectives established by these Councils.

- A description of how the Advisory Council establishes, reviews, augments or deletes such goals and objectives, as appropriate, by means of a continuing annual goal setting process which is: open, visible and accessible to the public pursuant to Section 5.07(a)(2) of the Mental Hygiene Law.

- A description of how the planning document, entitled, Statewide Comprehensive Plan for Mental Health Services 2001-2005, was prepared from local comprehensive plans developed by each local governmental unit pursuant to Section 5.07(b)(1) of the Mental Hygiene Law.

- A description of how the planning document is in conformance with the statewide goals and objectives established by the Advisory Council."

As of the date of this report, October 2002, the Office of Mental Health has not responded to the Assembly Chairman's information request, placed more than 16 months prior in June 2001. The OMH also did not submit an interim report, as required, on or before February 15, 2002, nor furnish the mandated annual update on or before October 1, 2002.

During the 2001-2002 legislative session, the Assembly Committees on Mental Health, Mental Retardation and Developmental Disabilities, and Alcoholism and Drug Abuse, held three public hearings regarding the organization of the Department of Mental Hygiene and the 5.07 planning process. None of the Commissioners of the Offices within the Department of Mental Hygiene testified at these public hearings, despite legislative requests to appear. They also did not respond to Assembly requests for a list of Advisory Council members for each Office or to inquiries for approved goals and objectives as specified by the Mental Hygiene Law.

Most persons testifying at these hearings, comprised of service providers, union representatives, local government health officials, mental health advocates and others, advised they had never heard of the IOCC and were not aware that the Offices were required by statute to work together to meet the needs of the multiply disabled. Criticism of the lack of planning by the Offices of Mental Health and Alcoholism and Substance Abuse Services (OASAS) was pervasive and consistent. The Assembly received several recommendations for improving the planning process.

The only exception to the general criticism received involved the Office of Mental Retardation and Developmental Disabilities (OMRDD). Most of the speakers addressing the planning process of this agency, while admitting that the OMRDD may not have followed the letter of the law, stated that OMRDD clearly had adhered to the intent of the law. However, testimony received from the New York Conference of Mental Hygiene Directors contradicted this finding by decrying its lack of involvement in the OMRDD planning process, which is inconsistent with the intent of the law.

Following are some excerpts from testimony received at the public hearings:

> 'Throughout the late 18th and most of the 19th centuries, the state looked to families and local authorities to provide care to its mentally disabled citizens….in 1890, the State Care Act was signed into law, putting an end to the system of county care and declaring the State of New York responsible for the care of all the pauper insane in the state….In 1912, the Commission in Lunacy became the State Hospital Commission. In 1927, it became the Department of Mental Hygiene...Responsibility for planning rested with the Commissioner…This arrangement lasted…until 1954, when the Community Mental Health Services Act was signed into law. This law reversed the policy of the State Care Act by authorizing localities to provide community mental health services under the direction of locally appointed boards…The development of community services set the stage for the revision of the Mental Hygiene Law in 1972, which recognized the principle that state and local governments share responsibility for planning and providing services…When the Department of Mental Hygiene was

split into three offices in 1977, the legislature established a planning process not only to create "maximum opportunity for cooperation" among the three offices but also to align state and local efforts.

"Section 5.07 of the Mental Hygiene Law is based on three principles. The first is that state and local governments must work together to address the needs of people who are mentally ill or mentally retarded. The second is that the needs of the mentally disabled will best be served if the three offices that comprised the Department of Mental Hygiene coordinated their activities, especially with regard to serving the needs of the multiply disabled. The third is that planning cannot be left entirely to public officials – that it must include the voices of all the people who are affected by mental hygiene policy – recipients of services, their families and advocates, providers, and interested citizens.

"The plan described in Section 5.07 is balanced and rational, both in terms of planning process and the plan's content. If such a process were ever engaged in and such a plan actually developed, we might be able to avoid some of the problems that have historically been associated with county care and state care. If there were an open public process for setting statewide goals and priorities, if the process were informed by data and grounded in locally identified needs, and if the plan were actually transformed into funding and programming to serve the needs of the people who are mentally disabled, the State of New York might once again find itself in the position it was a hundred years ago – a world leader in the provision of progressive, effective, and humane care to some of its most vulnerable citizens.

"Unfortunately, the gap between the ideals stated in section 5.07 and the realities of the state planning process is obvious to any interested observer…we look to you to re-energize the planning process – to provide not only the legal basis for planning, but the commitment and resources necessary to ensure that it will actually occur as it was envisioned twenty-five years ago." (**Testimony by Michael L. McClain, Associate Director for Community Affairs, Stony Brook Hospital, January 24, 2002**.)

"This so-called planning process often fails to take into account the extent of unmet needs, the appropriateness and efficacy of services provided, and the critical importance of maintaining a viable safety net of state operated services…The failure of OMH to document the specific capital needs at existing and proposed facilities, either in the 5.07 plan or any other document leads to additional skepticism…." (**Testimony by Roger Benson, President, Public Employees Federation, October 18, 2001**.)

"One of the clearest potential problems when the Department of Mental Hygiene was reorganized in the late 1970's was that newly autonomous Offices might unintentionally create barriers for persons suffering multiple disabilities. The IOCC was in part established to help mitigate such difficulties. As such, it was expressly granted statutory authority over statewide issues related to multiple disabilities. In the Conference's opinion, individuals with multiple disabilities and their families continue to face many barriers to services…The scope of this

problem is hard to quantify because the IOCC does not, we believe, provide an inventory of multiply disabled subpopulations which currently experience substantial barriers to care. Further, individual Office Five-Year Plans only report piecemeal on initiatives on multiple disabilities…one consequence is that third parties, including the State Legislature and watchdog groups, are not sufficiently alerted to a systematic issue which impedes responsive, effective and cost-efficient care to persons with a multiple mental disability**."** (**Testimony by David S. Brownell, Chairperson, New York State Conference of Local Mental Hygiene Directors, October 18, 2001**.)

"Having served the Albany County Department of Mental Hygiene for many years… it is evident to me that substantial gaps in service exist that block proper, safe and timely care to the Multiply Disabled population. The existence of these gaps suggests that the requirements of Section 5.07 of the Mental Hygiene Law, established to ensure that, among other things, services are provided to the Multiply Disabled, are not being given appropriate attention in the annual planning process….The Inter-Office Coordinating Council, or other similar bodies, may have a potentially powerful role in revising the planning process so as to promote county generated, cross system need specification." (**Testimony by Robin B. Siegal, Director, Albany County Department of Health, October 18, 2001**.)

"It gives me great pleasure to represent our Department and the Madison County Community Services Board (CSB) at this hearing today…the issue of compliance with Section 5.07 of the Mental Hygiene Law was identified by our CSB in February of this year. We were concerned that the state operating agencies…were not meeting their statutory obligations under this section. On February 2, 2001, Joan L. Smith, Chairperson of our CSB sent a letter to Commissioners James L. Stone (OMH), Jean Somers Miller (OASAS) and Thomas A. Maul (OMRDD) asking them about the implementation of Section 5.07…The bodies of the letters contained the following text:

> '…As you know, our Community Services Board is responsible for the planning, oversight and delivery of…services in Madison County. Under previous administrations, we have been able to inform our ability to carry out planning for such services through careful analysis of the current "Comprehensive Five Year Plan…" Our Board is distressed that there has been an apparent moratorium not only on the planning process, but also on additional resources for aid to communities, which are responsible to locally identified needs. We also cannot understand how the Governor's Office can responsibly prepare and finally approve a budget for the next fiscal year without an informed public process that provides a statewide perspective on needs, a plan with measurable goals and objectives to address these needs, and the directions to guide the localities in efforts to best meet these needs. As you know, the law requires such a document to be submitted by each October 1st. However, I do not believe there has been such a plan since the Cuomo Administration. Are we to believe that the Pataki Administration

> does not support a process that would identify unmet needs or wishes to hide from the fact that there is no plan to comprehensively address these needs? Our Board asks that you take immediate steps to meet your legal obligations under Section 5.07 so that we can better discharge our responsibility to the community...'

"In conclusion, I…know that all of our thoughts and energies have been directed into other areas as a result of the most recent terrorist events…It seems that this may be an appropriate opportunity to reinvigorate Section 5.07 and make it a useful vehicle to address the needs of our consumers." (**Testimony by James A. Yonai, Ph.D., Director, Madison County Health Department, October 18, 2001**.)

"I come before you sad, tired and frustrated…frustrated, for it is largely due to the lack of a plan for a comprehensive system of community-based mental health care that we continue to suffer the setbacks and indignities of the current mental health morass. Our system is gap-filled, staff-depleted, resource starved, hospital-heavy, jail-filled, consumer-unfriendly, failure-perpetuating and stigmatizing. In some ways, one might think it could not get any worse. But, 18 days ago, it did. With nary a whimper, the landmark Community Mental Health Reinvestment Act was allowed to expire. The only program in the state guaranteeing that funding from unused psychiatric center hospital beds will be used to meet community needs is gone…On August 2, 2001, MHANYS distributed, "A Framework for New York's Mental Health Future: Creating a comprehensive system of community-based care…"We continue to believe that creating an inclusive system of care, focusing on realignment of the present system, better utilizing our resources, reasonable compensation levels serving people in the least restrictive environment is paramount. We cannot and will not do without a plan." (**Testimony by Joseph A. Glazer, Esq., President/CEO, Mental Health Association in New York State, Inc., October 18, 2001**.)

"The Office of Mental Health has not completed and promulgated a detailed needs assessment of the mental health system for quite some time…The needed system of community facilities and support can only be built and maintained through a fair and equitable allotment of funds to mental health. It is necessary to assess the needs, determine the facilities, services and personnel required to fill those needs and allot a fair share of public funds to doing the job…There is nothing more essential to any person's well being than a safe and decent place to live…At present, there seems to be no assessment of housing needs and no ongoing program to meet them…there is almost no planning for family education…A statewide plan is needed to provide such education for the families of the mentally ill…..A sound mental health system can not be based upon discrimination against the mentally ill population and the caregivers who serve them, as is now clearly the case." (**Testimony by Michael J. Silverberg, President, National Alliance for the Mentally Ill of New York State, January 24, 2002**.)

"We believe that planning should be multi-dimensional, that it requires bottom-up participation to be meaningful and should be based on needs as best can be determined by quantitative and qualitative research as well as by the testimony of stakeholders…We are here to deliver a single message: that providers are suffering from the shortcomings of the current planning process and concomitant unavailability of utilization data. This has resulted in policies rooted in cost-controls, and not strategic, comprehensive system planning based on identified needs as historically has been the case…top down planning has resulted in shortchanging all of the stakeholders and mental health continues to fare poorly in the competition for scarce resources.

"It is clear …the most recent 5.07 plan that the State Office of Mental Health…comes up short in a number of areas. A full plan should do at least four things: it must describe the existing services within the system, but also demonstrate the existing need for services, forecast the services that will be needed, and establish a plan for filling the gaps/trimming the excesses in order to meet the forecasted need. The current SOMH driven document only describes the services that exist and how they meet the needs of the communities they already serve.…

"For any organization, an ability to forecast the future is central to long-term sustainable growth while maintaining quality services. In the mental health field, this is virtually impossible. Agencies regularly submit data as part of a patient characteristic survey – a noble effort by the state to track utilization, but the information only comes back after a minimum of two years – long after much of the data is useful…With insufficient and time worn data, it is impossible to forecast needed services. Without more local community and stakeholder input into the process, it is impossible to gauge the full dimension of need. With a clearer picture of need, services could be developed and funded to fulfill that need. A comprehensive and holistic annual planning process would link financial methodology to the true expense of delivering service. Such a process is one crucial and hoped-for outcome that will rescue community mental health from a serious crisis and restore faith in the commitment of government to serve its citizens in need." (**Testimony by Phillip A. Saperia, Executive Director, Coalition of Voluntary Mental Health Agencies, January 24, 2002**.)

Discharge Planning

Section 29.15 of the Mental Hygiene Law (amended in 1993, 1994, 1995 and 1999) delineates the responsibility of the Office of Mental Health regarding the discharge of patients from State operated psychiatric centers. This law requires written service plans, which shall include a specific recommendation of the type of residence in which the patient shall live, and a listing of the services available to the patient in such residence. Follow up is also required, including a determination as to whether a patient's living residence is adequate and appropriate for their needs, verification that the patient is receiving the services specified in the written service plan, and, recommendation of steps taken to assure provision of any additional services.

In August, 1993, the New York State Commission on Quality of Care for the Mentally Disabled issued a report, "Falling Through the Safety Net: 'Community Living' in Adult Homes for

Patients Discharged from Psychiatric Hospitals." The CQC revealed there was no follow through by the Office of Mental Health to ensure discharge plans and community residential placements were appropriate and adequate for patients being discharged to adult homes, as required by Section 29.15 of the Mental Hygiene Law. The CQC noted that failures resulted from precipitous discharges by State psychiatric center staff, placements in chronically substandard facilities, lack of follow up by discharging psychiatric centers, inadequate services and coordination of such by community based health, social services and mental health providers.

Nine years later, not much has changed. OMH has failed to follow the requirements of the law, as evidenced by the New York Times exposé of the substandard conditions and abuses suffered by thousands of mentally ill residents of adult homes and the placement of non-violent mentally ill persons discharged from psychiatric centers into secure units at nursing homes without appropriate due process **("Broken Homes/A Final Destination – 4/28/02; Broken Homes/Where Hope Dies – 4/29/02; Voiceless, Defenseless and a Source of Cash – 4/30/02).**

A June 3, 2002 article in the New York Times stated that OMH had been relocating many of the most profoundly mentally ill residents from Seaport Manor in Brooklyn to other adult homes that have their own histories of neglect. The MFY Legal Services, Adult Home Advocacy Project stated, in court documents related to Seaport Manor, that assessments of residents at Seaport being conducted by Kingsboro Psychiatric Center staff are grossly inadequate. MFY claims that these assessments include virtually identical mental status exams and diagnoses for each resident and fail to include a functional assessment that could determine whether adult home placement is appropriate for the residents.

Jeanette Zelhoff, Managing Attorney of the MFY Legal Services Mental Health Law Project provided testimony at a May 10, 2002 hearing on Adult Homes conducted jointly by the Assembly Committees on Aging, Health, Mental Health, Mental Retardation and Developmental Disabilities, and Oversight. Ms. Zelhoff stated:

> "The State Office of Mental Health (OMH) must stringently review the care provided to adult home residents by on-site mental health teams and must ensure that the teams are not puppets for the operators, but independent advocates and providers of services to residents."

In testimony provided to the Assembly at the May 10, 2002 public hearing regarding Adult Homes, Lisa Newcombe, Executive Director of the Empire State Association of Adult Homes and Assisted Living Facilities, asserted:

> "It does not appear to us that anyone is holding the outside provider system accountable. The Office of Mental Health, as the regulating agency for these providers, must do so. Its oversight system must have improved protocols to track the professional services provided to a resident and then to measure outcomes."

In response to a question posed at the May 10, 2002 public hearing, Mr. Alan Schulkin of the Public Employees Federation (PEF) reported:

> "…our Vice President…was a discharge planner at Kingsboro Psychiatric Center and what she was saying in the later years was it was a numbers game…They didn't care how you got people out of the hospitals, just as long as you got them out of the hospitals. Again, they give you inadequate staff and they tell you to place people. Find adequate homes for them, find adequate jobs for them and they don't give you the time or the resources."

Mr. Roger Benson, President of the Public Employees Federation (PEF) explained at the same hearing:

> "With an average loss from OMH every year, several hundred employees, it should become clear…that to create and monitor care of patients when they are discharged is virtually impossible." Mr. Benson went on to state that, "A significant part of the adult home problem stems from the lack of follow-up once an individual is discharged from any of these institutions. Oversight of facilities is not enough; we must provide continuous support to individuals."

Assemblywoman Pheffer requested OMH Commissioner James Stone respond to questions regarding the tracking of residents and other issues related to discharge planning at a second public hearing on Adult Homes in Albany, New York, on June 6, 2002. In response, OMH Commissioner James Stone stated:

> "By way of background, I would just remind everybody that people can recover from mental illness and people do recover from mental illness. So we never have any intention—ours is not a cradle-to-grave agency in which we track people with mental illness for the rest of their lives…"

In response to Commissioner Stone's statement, during the same hearing, Mary Rubilotta, Deputy Director for Contract Administration for CSEA, contended:

> **"**What happens to those chronically sick individuals who cannot return to inpatient status, who will never be skill-ready for more independent living…Very simple. They're transferred to adult homes and in substantial numbers. Through this squeeze play, the Office of Mental Health has successfully moved its back wards to the adult homes and can now claim that a population, which is most obviously theirs, is no longer their legal responsibility…The Office of Mental Health over an extended period of time has created the adult home problem you are reviewing today…We think that both OMH and the State have an obligation to continue tracking that population and make sure they are getting the care and services they need. So we would disagree with Commissioner Stone wholeheartedly."

Many people discharged from OMH inpatient facilities in recent years suffer from chronic mental illness. That is, they continue to experience the impacts of mental disability for substantial periods of time, in some cases for life. While Commissioner Stone's statement that some people recover from mental illnesses is true, it is also true that some do not. Section 29.15 of the Mental Hygiene Law does not state that the responsibility of OMH to develop a written service plan and monitor its implementation ends after a certain number of days, months or years. Section 29.15 is open ended in recognition that for certain chronically mentally ill

persons, the State has a cradle-to-grave responsibility, just as it does with the mentally retarded and developmentally disabled.

Reinvestment

Chapter 723 of the Laws of 1993 created the Community Mental Health Reinvestment Act (CMHRA). The Legislature determined that the reinvestment of resources accrued from the downsizing of the State operated mental health system into community based services would provide a funding mechanism for a comprehensive system of service delivery in communities throughout the State.

The promise was that all the savings accrued pursuant to this Act would be available for expenditure in the mental health system, thus providing significant funding for the expansion of community based mental health services. The original legislation, as amended, expired in 2001.

The commitment of the Governor to the promise of the Community Mental Health Reinvestment Act has been lukewarm at best. Since 1995, the Governor systematically underreported savings accrued by the downsizing of the State operated mental health system, removing significant resources that could have been used to stabilize and expand community based mental health services.

An internal memorandum from the Office of Mental Health, to the Division of Budget, dated June 3, 1993, placed an annual price per bed at $80,000. Factoring out savings that would be reinvested into state operated facilities; the memo stated the amount that could have been transferred to community-based programs was $64,000 per bed closed. The 1994 CMHRA required that initial savings would be no less than $57,500 per bed closed. Instead of using this figure as a floor, the Governor utilized it as a ceiling, effectively removing at least $6,500 per bed closed from the mental health system. Between 1995-1998, 1,475 beds were closed. Factoring in statutory cost adjustments and a conservative inflation factor of 2%, over $84 million was removed from the mental health system by the Governor in this one area.

In 1997, Governor Pataki proposed a 50% decrease in CMHRA funding and a 75% decrease in 1998-99. The Legislature denied this request. The media responded:

> "When he served in the state Senate, George Pataki assembled an admirable record for helping New York's most vulnerable citizens, the mentally ill…Yet now, three years into his first term as Governor, Mr. Pataki continues to turn his back on those very New Yorkers who still need state help in finding their way back into society…The state constitution imposes an obligation on New York to care for those least able to survive on their own. It's a duty that is doubly significant for the mentally ill…The money at stake comes from savings realized through downsizing and closing some of the underused psychiatric hospitals. It was money promised in good faith to a population that desperately needs it. Of all people Governor Pataki should know that." (Times Union, Albany, New York, February 17, 1997.)

> "It was a good idea back in 1994 when the state legislature passed the Community Mental Health Reinvestment Act and it's still a good idea. Unfortunately, it's

only half realized. That's because Gov. George Pataki has used half the money that was supposed to go to community programs for budget-balancing…the state has sent communities only $44 million more in annual savings, while it has saved $242 million annually by closing five institutions." The Daily Gazette, Schenectady, New York, April 30, 1997.)

The Governor continued to remove a percentage of savings from the mental health system during the period 1999-2001, as beds were closed, contrary to the promise of the CMHRA. In 2001, the Governor proposed an extension of the CMHRA but only if two psychiatric centers closed and certain state operated children's psychiatric centers relocated to the grounds of state operated adult facilities. The Governor stated these closings were necessary to free up funds to provide a cost of living adjustment (COLA) and a Medicaid rate increase to community based programs. Yet, the Assembly Ways and Means Committee completed an analysis of the Governor's assessment, based upon per bed savings, and determined there were sufficient funds available in the mental health system to provide for the proposed COLAs and Medicaid rate increases without requiring the two noted closings.

In further response, the Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities held a public hearing in Syracuse on February 14, 2001 to address the Governor's request to close the Hutchings Psychiatric Center located there. It was readily apparent that the statutory planning process delineated by Section 5.07 of the Mental Hygiene Law had not been adhered with regard to the proposed closings and consolidations. Given this reality, the Assembly rejected the Governor's proposed extension of the CMHRA and put forth its own extension removing the requirement for closings and consolidations until such time as a viable 5.07 planning process reflected the need for such actions. The Senate also rejected the Governor's proposal and introduced its own legislation. Due to the Governor's unwillingness to negotiate a compromise, he allowed the CMHRA to expire in September 2001.

Upon the expiration of the CMHRA, the Governor removed an additional $9 million from the mental health system in state fiscal year 2001-2002. Moreover, the Governor withdrew another $62 million from the mental health system general fund in the current fiscal year, 2002-2003. The facts document that these funds were more than sufficient to provide for the COLAs and Medicaid rate increases proposed for fiscal year 2001-2002 without the need for closings or consolidations, affirming the Assembly's position.

In 2002, the Governor did not propose a new CMHRA. Both the Senate and Assembly determined it necessary to maintain the promise to reinvest resources realized from the downsizing of state operated facilities into community-based programs. In June 2002, community reinvestment legislation passed both houses (Assembly Bill A.11604A, Senate Bill 7560). The legislation:

- Creates a new Section 41.56 of the Mental Hygiene Law entitled, "Community Mental Health Support and Workforce Reinvestment Program."

- Requires the OMH and Division of the Budget to develop a methodology to identify per bed savings at inpatient facilities to be reinvested. This methodology shall be shared with the Legislature for review and analysis.

- Provides a floor of $70,000 savings per bed closed.

- Ensures that funding provided pursuant to this section only be used to support mental health workforce related activities and other general programmatic functions to help foster a stable mental health system.

- Allows for additional reinvestment funds as facilities are closed, co-located or consolidated pursuant to the statutory planning requirements of Section 5.07 of the Mental Hygiene Law.

- Requires the OMH, beginning in October 2003, to submit, annually, a long-term capital plan for the future use of all mental health facilities.

- Provides up to 15% of reinvestment funds for staffing at state mental health facilities and at least 7% of these funds may be made available for state operated community-based services.

- Requires OMH, beginning October 2003, and annually thereafter, to provide a long-term plan for utilization of state employees and their role in the provision of an integrated and comprehensive system of treatment and rehabilitation for persons with mental illnesses.

To date, the Governor has failed to request the legislation be delivered for his review and approval consideration.

ADULT HOMES

> "As New York State decreased the size of its large State Psychiatric Hospital system, it increasingly relied on adult homes to provide housing and support for people with mental illness. Currently, 11,000 people with serious mental illness reside in adult homes. They comprise 30% of the congregate community housing for people with mental illness. Four out of ten persons living in adult homes have a mental illness." ("THERE'S NO PLACE LIKE HOME: Recommendations for Improving the Quality of Life in Adult Homes Serving People With Mental Illness," Executive Summary, Adult Home Work Group, June, 2000, p. 1.)

Protecting the frail elderly and the mental health of the people of the State are matters of public concern. Consequently, the State of New York has a responsibility to ensure that residents of adult homes, including the frail elderly and the chronically mentally ill, are treated with dignity and provided services they need in a caring and humane environment. The conditions in adult homes have been a matter of concern to the Legislature for many years.

In the 1990s, several statutes were enacted by the Legislature to ensure it received, on an ongoing basis, information necessary to enable it to carry out its constitutional responsibilities in support of the policy of the State of New York, to strengthen the regulation of the adult home industry, and create enriched services programs for chronically mentally ill persons residing in adult homes.

For several years, Governor Pataki has ignored the statutory reporting requirements related to the adult home industry leaving the Legislature and the public in the dark regarding conditions in adult homes. Moreover, the Governor has not used the statutory regulatory and enforcement

authority provided him by the Legislature to strengthen the State's oversight of the adult home industry. Exacerbating the situation, the Governor has reduced the number of state inspectors and removed experienced Department of Health administrators overseeing regulation of the adult home industry. Consequently, inspections, required by law of adult homes, were not completed.

Since 1991, the Legislature has fought for and approved a number of funding mechanisms in an effort to improve the adult home system. Over the past seven years, the Governor has hindered development of enriched programs authorized by the Legislature for chronically mentally ill persons residing in adult homes.

Reporting

Beginning in March 1995, Section 460(d) of the Social Services Law required the Department of Social Services, and then the Department of Health (DOH), to report annually to the Legislature on the regulation of adult homes and residences for adults. These annual reports were required by the Legislature so it could monitor conditions at such homes and take appropriate actions to remedy problems identified. The Legislature has not received this statutorily required annual report since 1997.

Section 461(m) of the Social Services Law requires the operator of an adult home to report any death or attempted suicide to DOH within twenty-four hours of its occurrence. DOH, in turn, is to report such incidences to the Commission on Quality of Care for the Mentally Disabled and law enforcement authorities, as appropriate. Neither DOH, nor its predecessor, the Department of Social Services, has enforced Section 461(m) since it was enacted in 1994**.**

Regulation/Enforcement

In 1993 and 1994, the Assembly Oversight Committee and Committee on Aging looked into issues of concern regarding the adult home industry. In August 1993, the CQC issued its report, "Falling Through the Safety Net: 'Community Living' in Adult Homes for Patients Discharged from Psychiatric Hospitals." The product of these efforts was passage of reform legislation – Chapters 733, 734 and 735 of the Laws of 1994. These laws provided the tools to improve state agency oversight of adult homes, improve the quality of care and service delivery, and strengthen residents' rights.

Section 460-d of the Social Services Law delineates the enforcement powers of DOH for facilities with violations. The New York Times identified a number of problems within adult homes in the New York City metropolitan area in 2001 and again in a series of articles in 2002. The untimely deaths of people under the age of sixty are a matter of particular concern. Some of the findings reported by the New York Times follow:

- DOH acknowledged it has never enforced a 1994 law that requires adult homes to report all deaths to the State within 24 hours.

- Some residents died roasting in their rooms during heat waves or succumbed to routinely treatable illnesses.

- Several homes are medical mills where residents are pressured to undergo treatment – even surgery – they neither need nor understand in order to get Medicaid and Medicare money.

- Adult home residents include many people who have no hope of self-sufficiency.

- The number of inspectors of adult homes dropped from 25 to 5 under Governor Pataki.

- The Governor's actions surfaced seven years into his administration during which time the inspection office was shrunk and many of the homes experienced their worst failures.

- The average death rate at one home, Seaport Manor, Brooklyn, New York, was one per month, in which many of the residents were ages 50-59.

These problems have existed for several years. On March 29, 1996, the Honorable Joan Christensen, Assembly Chairperson of the Administrative Regulations Review Commission and the Honorable Rhoda Jacobs, Chairperson of the Assembly Committee on Social Services, wrote to Brian Wing, Commissioner of the Department of Social Services, regarding Chapters 733 and 734 of the Laws of 1994. The letter to Commissioner Wing read:

> "As a result of a review of recent chapter laws we have determined that the Department of Social Services (DSS) is out of compliance with a statutory mandate which is contained in Section 6 of Chapter 733 of the Laws of 1994 dealing with the regulation of adult care facilities."

In 1996, instead of using his regulatory and enforcement authority to rectify the abuses at adult homes, Governor Pataki overruled his own inspectors and renewed the operator's license at Brooklyn Manor. The Governor's action was taken despite an administrative law judge's determination that the operator was unfit to operate the home, had refused to renew its license and imposed approximately $70,000 in fines. The New York Times, in an April 30, 2002 article entitled, "The Operators: Tainted Records and Family Ties" had this to say about Brooklyn Manor:

> "In 1991, a resident at Brooklyn Manor received $45,626 in retirement benefits, a veritable windfall in the world of adult homes. The money was entrusted to the home, and its operator, Benito Fernandez, took every penny of it, according to multiple reports by state inspectors.
>
> "It was not an isolated case. Throughout the early 1990's, state inspectors cited Mr. Fernandez and his associates for mishandling or misappropriating residents' money, as well as for poor conditions and supervision at the 216- bed home, in East New York.
>
> "Based on the inspectors' findings, the State Department of Social Services, which regulated adult homes at the time, refused to renew Mr. Fernandez's license. In 1996, an administrative law judge upheld the decision, citing overwhelming evidence.

> "The department had won, yet its senior officials soon withdrew the case against Mr. Fernandez, who is married to State Senator Nellie Santiago of Brooklyn. In addition, the senior officials rebuked the inspectors, taking away their authority over the home and giving it to inspectors based on Long Island. The records in the case contain no explanation for the state's reversal. State officials, repeatedly questioned in recent months about the case, would also offer none…
>
> "Last year, after The Times began investigating adult homes, the Health Department, which now regulates the homes, returned Brooklyn Manor to the city inspection office's jurisdiction. It found the home in disarray and cited it for many serious violations, including inaccurate, incomplete or nonexistent records."

In a September 15, 2002 article, entitled, "Despite Inspections by State, Violations at Home Continue," the New York Times reported:

> "In August, 2001, state inspectors uncovered numerous grievous violations at Brooklyn Manor, a 216-bed adult home for the mentally ill in East New York. One resident had matted hair and new and old blood stains on her face. Staff members were often absent. The distribution of psychotropic medicine was chaotic.
>
> "Yet the Department of Health took no action against the home, and so in June, 2002, inspectors returned. Nothing had changed, according to their reports, which was issued Friday.
>
> "Brooklyn Manor's administrator was withholding residents' allowances to punish them, the report said. Rooms were infested with flies, as was the kitchen. The home had not disclosed to the state that a resident had tried to commit suicide. The home could not account for more than $11,000 in residents' money that it was holding…
>
> "Asked why Brooklyn Manor was allowed to remain open, the Health Department said in a statement that it was closely monitoring the home.
>
> "When it issued the new inspection report on Friday afternoon, the department did not indicate what penalties it planned for the home, but after being questioned, department officials said they would seek a fine of $56,000."

In State fiscal year 1996-97, legislation proposed by the Governor and enacted by the Legislature, shifted regulatory responsibility for adult homes to DOH. However, the problems continued.

On November 4, 1999, The Office of the State Comptroller issued audit report #98-S-60, entitled "New York's Oversight of Adult Care Facilities." Audit findings included:

- Character and competency verification procedures were not being employed for the purposes of confirmation. For example, the Bureau of Licensing and Certification is responsible for the assessment of character, competence and financial viability of applicants for the DOH. When the Comptroller's Office asked to review the written procedures for the review of applicants, it was informed that the Bureau had not formalized the procedures.

- Although State law requires the licensing of each facility, the status of unlicensed facilities is often not resolved in a timely manner. Officials at DOH disclosed that they do not actively attempt to identify such facilities because their identification is not mandated by law and therefore is not a priority.

- Every adult care facility is required to receive a complete inspection every 12 to 18 months. However, throughout the State (especially within NYC) this is not the case. There was little documentation that suggests that inspections, when performed at all, were thorough and complete. The Comptroller found that many of the inspection activities required by the operating manual and NYCRR were not adequately documented in inspection files. In fact, officials at two DOH regional offices informed the Comptroller's Office that they were unaware of some of the requirements for inspections because they had never received the operating manual.

- According to Section 460 of the Social Services Law, if an adult care facility does not comply with applicable laws or regulations, DOH can close the facility; revoke, suspend or limit the operator's license; and/or impose civil or criminal penalties on the operator. The Comptroller's Office found that there were considerable delays involved when it came to actions to be taken against operators who violated rules and regulations. With DOH, five of the ten cases reviewed had been open for an average of 38 months but had yet to be resolved. Two remained open for approximately six years. The other five cases stayed open for an average of 45 months before being resolved.

- To determine whether hearing and settlement requirements were fulfilled, the Comptroller found that, in some cases, it was difficult to determine how a case had been resolved. Records were incomplete or unclear when providing information on fines paid or the status of corrective actions.

On May 1, 2001, the Chairmen of four Assembly Committees, Aging, Health, Mental Health, Mental Retardation and Developmental Disabilities, and Oversight, jointly wrote a letter to the Governor regarding serious concerns about the quality and safety of all of New York's adult homes. The Assembly followed up with the Governor on several occasions during the ensuing year to no avail. The Chairs of the four Assembly Committees determined it necessary to hold public hearings regarding the quality of care in adult homes. The following are excerpts from the hearings held on May 10, 2002 in New York City and June 6, 2002 in Albany:

> "I believe it is fair to say that we are all troubled and disheartened by the recent public accounts about conditions in some of NY's adult care facilities….Why do I feel when I read press releases from the Governor's office that they're merely making more promises? Why do I fear that promises made by the Executive as recently as May 8 are merely words—repeating promises made many times before. They promised reform in 2001, after the NY Times expose of the Leben House horrors. They made promises in August of 2001 to my Committee, together with the other Committees gathered here today, about promised fixes in the works. Promises were made in December, 2001…Again, they made promises

on April 30, 2002 calling for enhanced oversight. And promises were made again on May 3, 2002, announcing increased surveillance and new regulations and new legislation to 'fix the problem'….the system is broken and needs some serious attention in order to make it work better." (**Opening Statement, Honorable Jeff Klein, Chairman, Assembly Committee on Oversight, Analysis and Investigation, May 10, 2002**.)

"It is with both a sense of concern and a sense of frustration that we have convened the second of two hearings today to address issues regarding conditions at adult homes….It is the responsibility of the Governor to set the tone for his administration. For several years, Executive agencies have not met the statutory reporting requirements of law….

"The only time this Governor has responded to issues related to conditions at adult homes has been as the result of media exposure. In 2001, the Governor proposed a series of initiatives as a result of reports related to assembly line surgery on mentally ill patients at one adult home. On May 1, 2001, the chairs of the Committees convening this hearing wrote to the Governor calling on him to act. It took four months for his Commissioner of Health to respond and another two months for his Commissioner of Mental Health to respond. It took eight months for these agencies and the CQC to announce the signing of a memorandum of understanding regarding responsibilities related to adult homes, even though existing law has given each of these agencies significant authority to regulate the adult home industry. Then there was silence. No response to the Assembly's call for a thorough investigation into conditions at adult homes, no annual reports, no annual plans, no budgetary initiatives, only silence.

"In April of this year the New York Times, in a series of reports, exposed serious conditions at some adult homes. Suddenly, within days of the published Times articles and seven months before statewide elections for Governor, George Pataki broke his silence. While we commend the Governor for finally getting into the game, we must question where he has been on this issue for the past seven years.

"We must also question Governor Pataki's willingness to work with the Legislature to respond to this crisis. Silence appears to have been replaced by stonewalling. None of the Commissioners, of the responsible agencies, nor any of their senior staff, appeared before the Assembly's May 10th hearing, despite the Assembly requests. One public employee of the Health Department, an inspector of adult homes who was to testify on behalf of the Public Employees Federation (PEF), was notified by his superiors in DOH that he was to remain in Albany on May 10th for counseling.

"Subsequent to the May 10th Assembly hearing, Assembly staff attempted to meet with representatives of the responsible agencies to address issues raised at the May 10th hearing….On May 17th, an Assembly staff person was scheduled to meet with DOH staff responsible for licensing and surveillance of adult homes. On May 16th, our staff person was informed that the meeting could not go on as scheduled without the approval of…Assistant Commissioner of DOH…she

preferred setting up a briefing for the Assembly instead of individual meetings with DOH staff. Three weeks later this briefing has yet to be scheduled.

"…The Assembly has, historically, taken the lead to ensure that the most vulnerable among us are protected and that they enjoy a dignified, viable quality of life. The Assembly is prepared to carry out its constitutional responsibilities and will continue to work diligently to get the facts. We call on Governor Pataki to open the doors of his administration and allow the Legislature full, unfettered access to responsible agency staff and applicable documents. Together, as partners, we can make the broad systemic changes that are necessary." (**Opening Statement, Honorable Martin A. Luster, Chairman, Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities, June 6, 2002**.)

As of the date of this report, October 2002, the Assembly has yet to receive a briefing from the DOH.

"Basically, he couldn't be here…because he was not allowed. He was being disciplined. I don't know what the reasoning was and that's basically what the Health Department does. They terrify their employees if they are going to testify. Fortunately, I'm not worried. I'm confident your gonna have an early retirement so I can get out….

"Our findings are, and what we've been informed is that there is inadequate staffing of our employees. There are people who are being forced to act in professions they're not qualified for…Most of the time the Department of Health only reacts when the press gets involved and makes a big deal…I just say…when people say about enforcement, how can you have enforcement when you don't have staff?…This is the worst bureaucracy I've ever seen." (**Testimony by Alan Schulkin, Region 11 Coordinator, Public Employees Federation, substituting for August Cardinale, May 10, 2002**.)

"Contained in the regulatory reform mandates in the Governor's program bill of 1995, DSS was charged with streamlining ACF regulations. Following a thorough review of the regulations and extensive deliberations, most participants in the reform effort concluded that the regulations were not the problem…There was, however, considerable agreement that consistent and uniform interpretation and enforcement of the regulations by ACF surveyors was a problem. In short, we believe the real problem with the regulation and enforcement of ACF is:

1. The need for adequate funding for surveyor resources and training;

2. Interpretive guidelines, dissemination of best practices and other measures to foster more consistency and objectivity in the enforcement process;

3. More objective measures of quality such as outcome indicators; and

4. Specialized training for staff and a programmatic emphasis on care and services provided to mentally ill persons.

"It is unfortunate and frustrating that even these relatively minimal but sensible changes have not yet been implemented." (**Testimony by Carl S. Young, President, NY Association of Homes and Services for the Aging, May 10, 2002**.)

"Now I would like to speak on Seaport Manor…one of the largest homes in the New York City area. Given its long history of egregious violations of Social Services laws and regulations, serious allegations of negligent mental health care for its disabled residents, and the large number of deaths at the home, everyone was relieved to learn that enforcement proceedings had been instituted this past October. A review of the charges reveals that had the State sustained all the charges, the home could have been liable for close to half a million dollars. However…the State entered into a stipulation with Seaport operators…in consideration of a mere $20,000 in fines…if the $20,000 in fines is divided by the 79 deaths as reported in the Times, that would work out to $253 dollars per death…The laws are not self-enforcing. The State's various announcements of enhanced fines and penalties are all well and good, but without the will to enforce them, they are only a pretense…Unfortunately, it takes public humiliation to get the State to act…" (**Testimony by Jeanette Zelhof, Managing Attorney, MFY Legal Services Mental Health Law Project, May 10, 2002**.)

"I can't tell you strongly enough how, what a destructive public policy message the Health Department is sending out by allowing Seaport Manor to close with a mere slap on the wrist of $20,000. What is happening it is sending a message to operators, good and bad out there, that there is no accountability and you are also sending a message to…adult home residents everywhere that if you speak up and if you act for change that you will indeed be on the street." (**Testimony by Geoff Lieberman, Executive Director, Coalition of Institutionalized Aged and Disabled (CIAD), May 10, 2002**.)

"The appalling harm being inflicted upon vulnerable mentally ill adults living in adult homes which was described by the New York Times…described…a pattern of mismanagement and corruption which harms mentally ill adults who are supposed to be helped and protected by the state programs in which they are enrolled and which diverts public funds intended to help them into the pockets of people and organizations posing as their guardians…We call upon the Assembly and Senate to request that…a commission be appointed to investigate the Adult Homes Scandal…Through its investigations and public deliberations, attention will be sustained…Vulnerable populations of dependent people require an external source of power able to act on their behalf….There is no one government agency now with a coherent set of responsibilities, sufficient numbers of qualified staff, adequate funding and a clear accountability structure which can protect the mentally ill in adult homes. The 'Adult Home Scandal,' whose roots are that weak accountability structure, was simply waiting to be discovered by the public." (**Testimony by Louis Levitt, Past President, New York City Chapter of the National Association of Social Workers, May 10, 2002**.)

> "…Remove the profit motive. Clearly some adult home operators have been stealing from their residents and from tax paying citizens….Hire substantially more Health Department inspectors. There are currently only four state inspection employees in the state DOH office in New York City…Provide a continuous state presence through case management and state clinical services…Expand state operated community residences….Increase the use of shared staff….Enable state takeover of failing adult homes…..Ensure increased enforcement by the Office of the Attorney General….Finally, publish Commission on Quality of Care reports. In recent years the CQC… has published fewer reports, instead providing on presentations of its findings to select groups. This restriction of information violates their mission to provide advocacy….
>
> "…when we first came into the Department of Health we were told to be client friendly. Well the clients that we used to deal with in DSS were…mentally ill or welfare clients. Well, …now the clients they were referring to were the owners, not the clients of services, and we were told under no uncertain terms, don't look too hard and don't find too much." (**Testimony by Roger Benson, President PEF, May 10, 2002**.)

The Honorable Steve Englebright, Chair of the Assembly Committee on Aging, asked Mr. Benson to comment on the context of the Commissioner of DOH's public statement that many new inspectors were being hired and that miracles are being wrought. Assemblyman Englebright asked, "*Have you seen them?*" Mr. Benson responded:

> "No, we have seen no miracle work in the Health Department, but I can tell you as a thirty year Health Department employee myself, someone that served with pride under the leadership of Commissioner Axelrod, I'm frankly and personally embarrassed and humiliated by the current behavior of the leadership of that department."
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> "Now is the time for action…The Department of Health will not enforce the law. They don't even care to enforce the law, and they never will…And, more and more of our mentally ill will die this summer needless deaths because of the conditions that they live in. The Office of Mental Health has to be forced, forced to have the adequate housing for our population. Commissioner Stone doesn't want to hear it…I know it loud and clear, but they cannot wash their hands and walk away. They're not innocent. They're part of the problem. They have to be in it. They have to correct it. Governor Pataki has to stop vacationing and get himself down here. It's time for action. I think we've had more than enough commissions honestly." (**Testimony by Florence Weil, National Alliance of Mentally Ill in New York State, June 6, 2002**.)

<u>Enriched Services</u>

Since 1991, the Legislature has authorized enriched services to respond to problems identified in the adult home industry. However, the Governor actively hindered development of these enriched services. As a result, these programs were never allowed to achieve the results envisioned by the Legislature.

The Assisted Living Program (ALP) was established in 1991, authorizing 4,200 beds to prevent the costly and premature institutionalization of chronically mentally ill individuals. ALP enables an adult home to receive Medicaid reimbursement for residents in certified ALP beds. Eleven years later, the 4,200 beds authorized are not all operational.

The Limited Licensed Home Care Services Agency (LLHCSA) was created in 1995 to provide Medicaid funded home care services in adult homes so that residents are not forced into higher cost nursing home beds. It took the Governor three years to promulgate regulations establishing a fee structure for the LLHCSA. These regulations were so restrictive that they severely limited the ability of adult home operators to access this enriched service, costing the State many millions of dollars in potential savings. Advocates have estimated annual savings from this program, if fully implemented, would amount to approximately $200 million. Instead of helping mitigate the substandard care many residents of adult homes received, Governor Pataki's actions exacerbated the problem.

The Quality Incentive Program (QUIP) was established in 1996 to improve and reward adult homes that provide quality care to their residents. Six years later, regulations to implement this program still have not been promulgated by the DOH. According to testimony received by the Assembly at its public hearings on adult homes this year, DOH is at least two years behind in providing incentive payments to adult home operators who are providing quality services. The Governor proposed elimination of funding for this program in the current fiscal year. The Legislature, however, restored the QUIP and increased funding for the program.

Shortly after the April, 2002 New York Times exposé of the adult home industry in New York City, the Governor introduced legislation to address certain issues and created a work group to report and make recommendations regarding adult homes. On June 18, 2002, Assembly Bill #11783 was introduced to respond to issues identified by the Assembly related to adult homes.

In a June 17, 2002 press release, Assemblyman Richard Gottfried, Chair of the Committee on Health, stated:

> "Instead of offering a long-term vision for quality services and appropriate housing alternatives, the Governor responded with a legislative package of minimal first steps aimed at more effective policing, but little more."

Assemblyman Martin A. Luster, Chair of the Committee on Mental Health, Mental Retardation and Developmental Disabilities, responded:

> "This package is far stronger than the Governor's proposal. It addresses the underlying problems caused by a broken mental health system."

Assemblyman Steve Englebright, Chair of the Committee on Aging, purported:

> "Over the past decade, the Legislature created programs to improve care and services in adult homes. But the administration has hamstrung these programs with bureaucratic delays, under funding and regulations that block effective use of the programs. Our bill begins to fix these problems."

Assembly Bill #11783:

- Establishes a moratorium on admissions to adult homes which house 25% or more residents with mental disabilities or, in which 25 or more residents with mental disabilities live until inspected and certified by emergency action teams.

- Requires the DOH to conduct emergency background checks of all current adult homeowners and operators.

- Increases penalties for adult homes that violate the law or applicable regulations.

- Enhances the provisions of the Limited Home Care Services Agencies programs to residents who require either some or total assistance with activities of daily living.

- Creates a striving for excellence program to provide financial enhancements to adult home providers who consistently provide residents with a high quality of care.

- Establishes an adult home quality enhancement fund to be distributed by the CQC to ensure that, among other things, legal services and advocacy are available to adult home residents and to promote innovative programs to improve the quality of care in adult homes.

- Gives the Attorney General the statutory authority to investigate and prosecute adult homeowners, operators, associated individuals and entities, and public officials or employees as well as any other crime or offense arising out of such investigations or prosecutions.

- Establishes a temporary advisory council on adult home reform consisting of members appointed by the Governor and both Houses of the Legislature.

- Clarifies the utilization of the quality incentive program.

Assemblyman Jeffrey Klein, Chair of the Committee on Oversight, furnished the following synopsis on Assembly bill 11783:

> "Our bill gives the Attorney General's Office power to investigate and prosecute any criminal issues in the regulation, oversight, and operation of the adult home industry. It's important that this power is given to someone who is independent of the Administration."

On June 26, 2002, the Chairs of the four Assembly Committees forwarded joint correspondence to Governor Pataki stating:

> "We are aware that you have convened an adult home workgroup to address some of the deficiencies existing in adult homes caring for mentally ill individuals. While this workgroup includes representatives from various state agencies with responsibilities to oversee adult homes or the provision of services to the mentally ill and advocacy organizations, it is distinctly noticeable that the workgroup lacks

representation from both houses of the legislature. We ask that such representation be included.

"The legislature would offer a unique perspective and valuable input into the viability of corrective measures. When questioned about the legislature's inclusion in this workgroup at the Assembly's June 6, 2002 public hearing on adult homes, Department of Health Commissioner Novello stated that representatives from the Assembly and Senate certainly could be included in the workgroup.

"We request information regarding the structure of the workgroup, the progress made in addressing these issues, and any other pertinent information that would facilitate legislative participation. As we understand, the workgroup has broken out three sub-groups to address various aspects of the larger problems facing adult homes. We would like to have representatives from the Legislature included in all of the sub-groups as well.

"Thank you for your cooperation and consideration. We look forward to participating in a meaningful way to provide better housing, services and treatment for individuals residing in adult homes."

As a follow-up to the June 6, 2002 public hearing, on August 12, 2002, the four Chairs also wrote to the Commissioners of DOH, OMH, the Department of Aging and the Chairman of the CQC. The letter states, in part:

"We sent a letter dated June 26…regarding the Workgroup's charge, make-up and activities, as well as legislative participation. To date, we have not received a response to that letter…

"Subdivision 10 of Section 460-D of the Social Services Law requires an annual report by the Department of Health to the Governor and Legislature setting forth results of inspections and enforcement actions, audits of financial conditions of select homes and recommendations for legislative action. We are in possession of a 1996 report, released May of 1997. Both before and at the public hearing we requested any prior reports issued, as well as reports issued since then. Deputy Commissioner Whalen assured us that the information existed and he promised to provide the information to us. We are aware of the current enforcement information posted on the DOH's web site; however, the statutory report includes information that goes beyond the DOH website…

"At the June 6th hearing, Commissioner Stone testified that OMH would be 'publishing (the) 5.07 report toward the end of this month (June), possibly July.' At this time, we still have not received a copy of the report. We request a copy of the 5.07 report that complies with the requirements of the law, including the services provided to mentally ill adult home residents...

"Limited Home Care License Program: We are interested in receiving the report required pursuant to Section 105-f of Chapter 81 of the Laws of 1995. This was due on or before June 26, 1997…

> "We look forward to hearing from you as soon as possible with this requested information."

On September 23, 2002, the Governor's adult home workgroup released its report and recommendations. On September 24, 2002, the New York Times, in an article entitled, "Panel Urges Change in New York Homes for the Mentally Ill," reported:

> "Administration officials said the proposals could have many revisions in the coming weeks, particularly as their costs are closely examined. They said Dr. Novello would issue a final report outlining the panel's work, and plans for adopting it, at the end of October."

Again, on October 21, 2002 the four Chairs wrote to DOH Commissioner Novello and OMH Commissioner Stone.

> "We are writing to reiterate the requests made at the Assembly's hearing on adult homes on June 6. At the hearing, we were told that we would receive the requested information…Four months have elapsed since our hearings were held and we requested this needed information, yet no response from the Department of Health has been provided.
>
> "At the hearing, the Department promised to structure a role for representatives of the two houses of the Legislature in the adult home workgroup. You did not do so, despite our follow-up letters. In addition, in our August 26 letter we asked to be apprised of workgroup meetings and agendas. Now the workgroup is finishing its tasks.
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> "In addition to our concerns about the workgroup, our letters sought information regarding: reports setting forth results of inspections and enforcement actions, audits of financial conditions of select homes, recommendations for legislative action, the report required by Section 5.07 of the Mental Hygiene law, the report on the Limited Home Care License Program, information regarding death reporting, and the total amount recouped from Ocean House.
>
> "Your refusal to communicate with the Legislature casts serious doubt on your commitment to resolving the adult home crisis in a professional way. Furthermore, your failure to provide us with the requested information suggests that required reports were never issued; that monies from Ocean House were never recouped; and that the Executive does not truly seek the full participation and involvement of the legislature in addressing problems identified to date.
>
> "We insist that you fulfill your statutory obligations and oral commitments and provide the required information. Please notify us promptly of your intentions so that we can avoid the necessity of reconvening the hearing and compelling the production of the required information."

While the Assembly focused on issues raised at its public hearings, the New York Times, in an October 8, 2002 article entitled, "Mentally Ill, and Locked Away in Nursing Homes," revealed:

"Hundreds of patients released from state psychiatric hospitals in New York in recent years are being locked away on isolated floors of nursing homes, where they are barred from going outside on their own, have almost no contact with others and have little ability to contest their confinement, according to interviews with workers and experts and visits to the homes.

"The Pataki administration approved the creation of the special units for the mentally ill in 1996, but has otherwise left them unregulated. The nursing homes generally lack mental health expertise, and have not sought licenses to operate locked floors.

"As a result, some experts said, the administration was allowing the homes to violate state regulations governing the care of the mentally ill and in the process was depriving them of their civil rights…As the state continues to empty out its costly psychiatric hospitals, it appears to be moving even further from what it says had been a fundamental goal: helping the mentally ill gain independence and self-sufficiency to live within a community…

"Administration officials said they did not know exactly how many units were operating. The State Office of Mental Health estimated that at least a dozen existed, suggesting that as many as 1,000 mentally ill people live in them. Yet the office, which was responsible for discharging the patients from the state psychiatric hospitals to the units, has chosen not to take a role in overseeing them or ensuring that residents receive proper care.

"Many mental health advocates and lawyers were unaware of the units and voiced dismay when told of the restrictions.

'I have never heard of this type of facility in the 12-plus years that I have been doing this," said Tim Clune, Managing Attorney for Disability Advocates, a nonprofit legal office in Albany. 'I am surprised that this exists, and that the state would allow this to exist. This is de facto involuntary commitment. These people's civil rights are being violated…'

"In addition, the residents have not been deemed by the state to be a danger to themselves or others, which is typically the legal standard used to keep someone in a locked hospital psychiatric ward. Because the units are not licensed as psychiatric facilities, the residents also do not have the legal protections guaranteed to patients committed to psychiatric wards: the right to a lawyer, and to a hearing to contest having their freedom taken away.

"The units were first developed in the mid-1990's by Mr. Landa, one of the city's most prominent nursing home operators, and his staff in conjunction with the administration.

"Mr. Landa has been a major contributor to Governor Pataki's campaigns and was appointed by the Governor to the State Public Health Council, which is an arm of the State Health Department that helps regulate hospitals and nursing homes.

> "Mr. Landa is a partner in four nursing homes that have a total of 200 beds in the special units…
>
> "The State Public Health Council has opted not to require regulation of the units, which have since gone on to accept patients from psychiatric wards of general hospitals as well. Regulations typically are intended to ensure that residents receive proper mental health services and that their rights are being protected…
>
> "The state mental health commissioner, James L. Stone…called the units excellent long-term housing. 'They have met a real need for some people who have been languishing in our state hospitals,' he said.

The Assembly reviewed legislative and budgetary proposals for the past seven years to ascertain whether the Governor had ever requested legislative approval for these secure housing units in nursing homes or whether the Legislature had ever authorized such units. The Assembly could find no such documentation. It appears that this action by the Governor violates Article XVII, Section 4 of the New York State Constitution, which states that the care and treatment of persons suffering from mental disorder or defect…may be provided by state and local authorities and in such manner as the legislature may from time to time determine.

CONCLUSION

The New York State Constitution and the laws of New York State delineate the responsibilities of the Executive branch of government to the people of this state and its elected representatives. The State Constitution establishes the framework of New York State government. It is intended to formalize the mechanisms which ensure that the trust placed by the people in their public officials is not violated and to limit the ability of the Executive to impose its will upon the people, to limit their rights and freedoms, without the cooperation and approval of the popularly elected representatives of the legislative branch of government.

Consequently, Article IV, Section 3 of the Constitution states that, "The governor shall…expedite all such measure as may be resolved upon by the legislature, and shall take care that the laws are faithfully executed."

The framers of the State Constitution also recognized that providing for the health and welfare of its residents is a primary function of government. They acknowledged that one of the measures of a free people, organized for the common good, is how a society protects its most vulnerable citizens. Consequently, Article XVII of the state Constitution expresses the responsibility of the State regarding the poor.

Section 4 of this Article addresses the most vulnerable of our residents, the mentally disabled. Section 4 states:

> "The care and treatment of persons suffering from mental disorder or defect and the protection of the mental health of the inhabitants of the state may be provided by the state and local authorities and in such manner as the legislature may from time to time determine."

The laws of the State of New York set forth, among other things, the specific responsibilities of the Executive branch of government to the Legislature and the people. The Mental Hygiene Law and the Social Services Law are two such laws.

In addition, pursuant to the fiscal policy of the State, as proposed by the Executive annually and approved by the Legislature, public funds are apportioned to address identified needs within the State. Incumbent in this fiscal process is the responsibility of the elected representatives of the people to be good stewards of public resources.

In early, 2001, Governor Pataki proposed closing two State-operated psychiatric centers and relocating several children's psychiatric facilities onto the grounds of adult psychiatric centers. This proposal provided the impetus for the Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities to undertake a comprehensive review of the mental health service delivery system.

The Committee was hindered in its review by the fact that, for the past seven years, the administration of Governor Pataki has not complied with the statutory planning and reporting requirements of the law regarding the mentally ill. In addition, the lack of cooperation by Executive branch agencies responsible for issues related to the mentally ill, including the Department of Health and the Office of Mental Health, further complicated the Committee's undertaking.

The mental health service delivery system is broken. The failure of Governor Pataki to faithfully execute the laws of the State of New York and to expeditiously implement the laws approved by the Legislature created a public health crisis and is a violation of the public trust.

The consequence has been a disjointed, top down planning process that is inefficient, facilitating wasteful use of public resources. As a result, thousands of mentally ill persons have suffered indignities and abuse. Hundreds of others have suffered untimely deaths due to a dysfunctional mental health system.

Far from protecting the health and welfare of its citizens, the State has allowed the mentally ill to be treated as chattel by unscrupulous individuals for their personal profit. The recent revelations, as reported in the New York Times, that since 1996, harmless mentally ill persons were being locked away in nursing homes without legislative approval or due process of the law is just the latest symptom of a system gone awry.

The New York State Assembly has, historically, taken the lead in protecting the State's most vulnerable residents. The Assembly will continue to do so.

The Assembly will require the cooperation and participation of the Governor and the Senate to complete a restructuring of the Department of Mental Hygiene and the mental health service delivery system.

The Committee regrets that, with regard to the care and treatment of mentally ill residents of adult homes, it has had to rely, to some extent, on investigative reports of the media. At the same time, the Committee is grateful that the media has exercised its role in the oversight of the operation of government as the eyes and ears of the people.