Things That Community Services Board Members Should Know

(Charter County version)

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Today's Training Will Cover:

- History of the Mental Hygiene System.
- Article 41 and Community Mental Health.
- Mental Hygiene Services Programs and Financing.
- A bit about Medicaid and the LGU role.

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History of the NYS Mental Hygiene System

- **1843** - (Chapter 82) the first mental health institution, the State Lunatic Asylum at Utica, opened. **Local governments were responsible for expenses of "inmates" at these asylums** and many local governments also continued to confine the mentally ill in jails and poorhouses.
- **1867** - (Chapter 951) State Board established to **inspect** and report to the legislature on all publicly funded charitable and custodial institutions.

Originally a mental illness system

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History of the NYS Mental Health System

1873

(Chapter 571) Legislature created State Board of Charities Mandated licensing of public and private institutions for the mentally ill

1890

There were nine additional State asylums for the mentally ill. State had taken on the entire responsibility for the care of New York's mentally ill.

1912

(Chapter 121), State Hospital Commission given responsibility for the administration of the State's mental hospitals.

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Developmental Disabilities recognized.

1851-The first special care state institution, the New York State Asylum for Idiots, was established near Albany.

1855- The Syracuse school opened designed for children with intellectual and cognitive disabilities

1918(Chapter 197) State Commission on the Feeble-Minded established. (*ID/D* . There are **five State special-care institutions**.

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1926 – Mental Hygiene became a reality.

.**1926 – Mental Hygiene became a reality**.

The Department of Mental Hygiene was established (Chapter 584) as part of the 1925-26 constitutional reorganization of State government taking over functions of the State Hospital Commission and the State Commission for Mental Defectives, which were abolished.

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Movement from Institutions to the Community

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1954 – The New York State Community Mental Health Services Act was passed. The act encouraged localities to establish community-based mental health programs and to apply for state reimbursement of up to 50% of the cost of these programs.

Net Deficit Funding

- *Provider collects all other sources of revenue from insurances, private pay, donations etc.*
- *The difference between the provider's expenses and the collected revenue is calculated.*
- *The difference, called the **Net Deficit** is paid 50% by the State and 50% by the local government.*

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In 1955 New York's Inpatient MH population peaked at 93,600

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- In 1984 NYS Inpatient population was 32,000
- By 2011 NYS Inpatient population dropped to around 3,900.
- **Today it is about 2500.**

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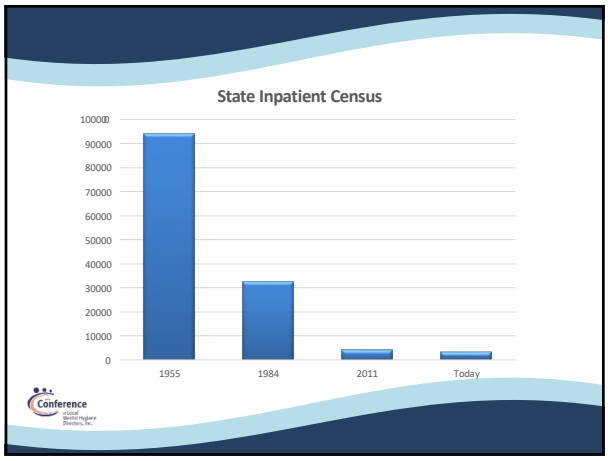

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What caused the movement from Psychiatric Hospitals ?

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Introduction of Psychiatric Medications

1950's
The first antipsychotics were produced in France.
- **Chlorpromazine (Thorazine).**

1950's
Tricyclics and monoamine oxidase inhibitors for depression.

Early 1960's
Benzodiazepines to treat anxiety.

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Deinstitutionalization from Psych Hospitals

Late 1960's, 70's and early 80's. The problems associated with the policy of mass discharges (deinstitutionalization) from state hospitals into local communities (without transferring resources) became increasingly evident:

- Lack of continuity of care.
- Failure to meet the needs of the seriously mentally ill.
- Increases in homelessness.
- Increased involvement with the criminal justice system.

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Deinstitutionalization for the ID/D Population

1970s- At maximum there were 20 state DCs housing more than 27,000 people with intellectual and development disabilities.

1972- Geraldo Rivera report on Willowbrook-and the story of Willowbrook becomes public- parents of 5000 Willowbrook residents file suit in federal court.

1974- State schools became Developmental centers.

1975- Willowbrook Consent decree- finally approved in 1987.

1978- Site selection law-(Padavan law) takes effect providing a way around NIMBY problem of siting group homes.

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1990- The Americans with Disabilities Act (**ADA**)

Title II of the ADA provides that "[s]ubject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." Under Title II, a "public entity" includes "any department, agency, special purpose district, or other instrumentality of a State or States or local government."

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THE OLMSTEAD DECISION

1999 - The Supreme Court issued its opinion in ***Olmstead v. L.C.***, which held that it is a violation of the Americans with Disabilities Act to keep individuals in restrictive inpatient settings when more **appropriate community services** are available.

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- 1995- George Pataki becomes Governor
  - Reversed decision to close DCs primarily because they were a revenue generator.
  - NY eventually overcharged Medicaid about 15 billion dollars which had to be paid back.
  - LGUs basically frozen out of a real local role.
- Feds became serious about enforcing Olmstead.
  - In 2017 the Bernard Fineson Center in Queens closed leaving only two residential centers that continue operating.
    - Sunmount Development Center in Tupper Lake (Franklin County).
    - Valley Ridge Center for Intensive Treatment in Norwich (Chenango County) .
- Role of LGU became more important as OPWDD now had responsibility for many people in the community who needed other services in the community.

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- **2010** - The Office of Mental Retardation and Developmental Disabilities was renamed as the **Office for People With Developmental Disabilities (OPWDD).**

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The Development of the SUD Bureaucracy

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1966 - (Chapter 192) Narcotic Addiction Control Commission (NAC) created within the DMH
- Supervise alcohol and narcotics-addiction treatment centers
- Coordinate community rehabilitation and prevention programs.

1973 - (Chapter 676) NAC renamed the Drug Abuse Control Commission (DACC).
1975 - (Chapter 667) DACC replaced by the Office of Drug Abuse Services.
1977- (Chapter 978) established the Office of Alcoholism and Substance Abuse with two divisions.
1992- (Chapter 223)- the **Division of Alcoholism and Alcohol Abuse and the Division of Substance Abuse Services were consolidated** into one Office of Alcoholism and Substance Abuse Service
2019- (Chapter 281) renamed **Office of Addiction Services and Supports.**

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Reorganization of the Department of Mental Hygiene in NYS

1977 (Chapter 978)

Department of Mental Hygiene

- **The Office of Mental Health (OMH)**
- The **Office of Mental Retardation and Developmental Disabilities (OMRDD)**
- The **Office of Alcoholism and Substance Abuse (OASA)**
  - Ø Division of Alcoholism and Alcohol Abuse
  - Ø Division of Substance Abuse

Article 41, creating the LGU and a state- local partnership becomes law.

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The Federal Beginnings

July 3, 1946 - President Truman signed the National Mental Health Act, which included a significant amount of funding for psychiatric education and research.

1949 - National Institute of Mental Health (NIMH) created.

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Major changes of the 60's on the Federal Front

1963 - President Kennedy proposed and signed legislation that started community mental health center movement to substitute comprehensive community care for custodial institutional care. It provided additional funding for community mental health centers.

1965 - Medicare and Medicaid were established. Provided for a federal share of the cost of health care. Both contained provisions for mental health treatment, but the care furnished in state hospitals was explicitly not covered ***(the IMD exclusion)*** and mentally ill people under the age of sixty-five were ineligible for Medicaid benefits. These provisions resulted in the transfer of large numbers of the elderly mentally ill from state hospitals to nursing homes.

IMD Exclusion

- prohibits states from using Medicaid to pay for care provided in "institutions for mental disease" (IMDs), which are psychiatric hospitals or other residential treatment facilities that have more than 16 beds.

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The Ups and Downs of the early 80's

1980 – (Carter) The Mental Health Systems Act, (P.L. 96-398), restructured the federal community mental health center program by **strengthening the linkages between the federal, state, and local governments**. It included an expansion grant for a wide range of services for the severely mentally ill (SMI) and the severely emotionally disturbed (SED) populations. The commission sought to include consumer input and involvement in service and treatment.

1981 – (Reagan) Omnibus Budget Reconciliation Act of 1981 revoked the Mental Health Systems Act. **American mental health policy was once again the responsibility of the states and of localities**. Federal government began a retreat from the Mental Health System. President Reagan sought to dismantle or shrink many social welfare programs.

- Cut federal support by 25%
- Forward federal monies to the states in block grants) to allow each state to devise its own mental health and substance abuse treatment policies. Less federal share.

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Some other important events

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Reinvestment

1993 - **The New York State Community Mental Health Reinvestment Act** mandated that all savings realized from the closure of unneeded state psychiatric centers be funneled to community mental health programs. The act was propelled in part by the OMH's intention to close several facilities.

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Paul Wellstone and Pete Domenici
Mental Health Parity and Addiction Equity Act of 2008

- **The first parity law passed in 1996**. It was limited to preventing larger plans from setting lower annual or lifetime dollar caps on mental health benefits than for other health benefits.
- **The 2008 law** Extended parity protection to:
- All group plans which offer medical, surgical and MH/SA benefits if there are 50+ employees in the group
- Medicaid Managed Care plans
- State Children's Health Insurance Programs (CHIP)
- Non-Federal Governmental plans
- Applies to Medicaid benchmark plans beginning in 2014

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Federal Parity rules require that:

- Mental health and substance use disorder benefits must be "**no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits** covered by the plan…"
- "There are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorders benefits.
- Plan may not apply any **financial requirement** or **treatment limitation** to mental health or substance use disorder benefits **in any classification** that is more restrictive than the **predominant** financial requirement or treatment limitation for **substantially all** medical/surgical benefits in the same Classification
- May not impose Non-Qualitative Treatment Limitations (NQTL) (e.g. formularies, networks, step therapy) for MH/SUD in a more restrictive manner than for M/S care.

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Parity in New York

- Insurance regulation 11 NYCRR PART 230
- Effective December 29, 2020.
- Under the new regulations, parity compliance programs must establish corporate governance for parity compliance, identify discrepancies in coverage of services for the treatment of mental health conditions and substance use disorder, and ensure appropriate identification and remediation of improper practices

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FEDERAL HEALTH CARE REFORM

The Affordable Care Act (enacted in 2010) includes an Essential benefits requirement which must include (among a menu of services) emergency treatment, prescription drugs, **mental health and substance abuse treatment services**.

Requires that all "qualified health plans" offered through the exchanges must comply with the Domenici-Wellstone Mental Health Parity and Addiction Equity Act of 2008.

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Article 41: Local Services

Article 41 is the Constitution of the LGU.

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Article 41: Local Services

- "This article is designed **to enable and encourage local governments to:**
  - **develop** preventive, rehabilitative, and treatment services offering continuity of care;
  - **to improve and to expand existing community programs** for the mentally disabled (MH, DD and SUD);
  - **to plan for the integration of community and state services and facilities** for the mentally disabled;
  - **and to cooperate with other local governments** and with the state in the provision of joint services and sharing of manpower resources.

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Article 41: Purpose

Article 41 is designed to create a process that governs a **joint** effort between state and local units with regard to the **planning for and the financing** of mental hygiene services in New York.

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Definitions

"**local government**"- the city of New York and the other 57 counties

"**charter government**" means a local government which has its charter under article IX of the constitution and the municipal home rule law; and includes the city of New York.

"**local services**" includes services for the mentally ill, the mentally retarded, the developmentally disabled whose conditions, including but not limited to cerebral palsy and epilepsy, are associated with mental disabilities, and those suffering from alcoholism, alcohol abuse, substance abuse or substance dependence, which are provided by a local government or by a voluntary agency pursuant to a contract with a local governmental unit or the office of mental health.

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"**local governmental unit**" means the unit of local government given authority in accordance with this chapter by local government **to provide** local services.

"**board**" means a **community services board** for services to the mentally ill, mentally retarded and developmentally disabled, those suffering from alcoholism, alcohol abuse, substance abuse, or substance dependence.

"**director**" means the **director of community services**, who is the chief executive officer of a local governmental unit, by whatever title known.

"**local services plan**" means the plan of local services which is submitted by a local governmental unit and approved by the commissioner pursuant to MHL §41.18

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Local Services Plan

A Local Services Plan is a plan for the rendition of local services. The plan must:

- include involvement of consumers, consumer groups, voluntary agencies and other providers of services.
- be approved by the commissioner in order to be eligible for state aid.
- contain a comprehensive proposal for annual and intermediate range plans and expenditures by the local governmental unit and by voluntary agencies pursuant to contract with such local governmental unit.
- contain provisions to assure that there is planning and coordination with the delivery of community support services to mentally ill persons, in accordance with MHL 41.47.
- be supported by specific budgets.

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Goals of the Plan

- All population groups are adequately covered
- Sufficient services are available for all the mentally disabled within its purview,
- That there is coordination and cooperation among local providers of services,
- That the local program is integrated and coordinated with the provision of community support services,
- That the local program is also integrated and coordinated with the programs of the department, and
- That there is continuity of care among all providers of services.

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MHL 5.07 Statewide Plan

(b) Statewide comprehensive plan for services to persons with mental disabilities. The three Mental Hygiene Offices are required to formulate a statewide comprehensive five-year plan for the provision of all state and local services for persons with mental illness, developmental disabilities, and/or those with substance use or compulsive gambling disorders.

The statewide comprehensive plan shall be based upon an analysis of local services plans developed by each local governmental unit, in consultation with consumers, consumer groups, providers of services and departmental facilities that furnish behavioral health services in conformance with statewide priorities and goals established with recommendations of the behavioral health services advisory council and the advisory council on developmental disabilities.

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CLMHD Website Contains 3 years of Local Services Plans

- Visit www.clmhd.org
- On the CLMHD homepage, click on "Contact Local Mental Hygiene Dept"
- Click on any county on the map
- To the right of the DCS name, you may click on 2017, 2018 or 2019 Local Services Plans

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The Local Governmental Unit (LGU)

MHL§ 41.05 requires that, in order to be eligible for State Aid, a local government must establish a local governmental unit (LGU) as an identifiable entity.

- The LGU is ***required to have a board*** known as the community services board for services to the mentally ill, the intellectually and developmentally disabled, and those suffering from substance use disorder.
- The LGU is also ***required to have a Chief Executive Officer*** to be known as the Director of Community Services.

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Powers and Duties of Local Governmental Units (§ 41.13)

- **Review services and local facilities** for the mentally disabled
- **Develop the program of local services** for the area which it serves, establish long range goals and develop intermediate range plans and forecasts.
- **Direct and administer the development of a local comprehensive plan.**
- **Submit annually** to the department for its approval and subsequent state aid, a report of long range goals and specific intermediate range

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Powers

- **Have the power**, with the approval of local government, to enter into contracts for the provision of services and the construction of facilities
- **Establish procedures** for execution of the local services plan
- **Make policy for and exercise general supervisory authority over or administer** local services and facilities provided or supervised by it whether directly or through agreements.
- **Administer, supervise or operate** an AOT program
- **Identify and plan** for the provision of care coordination, emergency services, and other needed services for high need persons.
- **Each LGU has full powers** necessary for administration and the execution of its duties.

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Enter the World of the Community Services Board

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Community Services Board (§ 41.11)

The Community Services Board in a Charter County may either be a policy making or an advisory Board of Directors of the LGU.

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The Difference Between Chartered and Non Chartered Counties

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Who Makes Policy?

Article 41 states:

Chartered governments may vest policy-making functions **in either the Director or the Board.**

In **Non-Chartered** Counties the **Community Services Board** has the policy-making function.

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List of Charter Governments

Albany	Monroe	Rensselaer
Broome	Montgomery	Rockland
Chautauqua	Nassau	Schenectady
Chemung	Oneida	Steuben
Dutchess	Onondaga	Suffolk
Erie	Orange	Tompkins
Herkimer	Putnam	Ulster
	New York City	Westchester

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Role of the CSB Under a Charter

MHL 41.05 (c) - the Charter determines whether the policy making authority shall be vested in the CSB or the DCS.

Charters in NY generally vest policy making authority in the DCS who generally serves at the pleasure of the Mayor, County Executive or County Legislature.

In these cases the CSB is deemed to be advisory only.

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Opinion of Attorney General 2011-F1

1. Recognizes practice which permits local governments which have adopted a charter form of government to have a Department of Mental Health with an advisory board.
2. Every local governmental unit must have a CSB but in charter forms of government the local government has the option of making such a board advisory rather than executive.
3. In chartered counties, the Director of Community Services may be appointed in the manner authorized by such governments.
4. In local governments which have not adopted a charter form of government, the board appoints the director.

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Charter Provisions

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NYC charter

§ 568. Mental hygiene advisory board. a. (1) There shall be a mental hygiene advisory board which shall be advisory to the commissioner and the deputy commissioner for mental hygiene services in the development of community mental health, mental retardation, alcoholism and substance abuse facilities and services and programs related thereto. The board shall have separate subcommittees for mental health, for mental retardation and developmental disabilities, and for alcoholism and substance abuse. The board and its subcommittees shall be constituted and their appointive members appointed and removed in the manner prescribed for a community services board by the provisions of the mental hygiene law. Pursuant to the provisions of such law, such members may be reappointed without limitation on the number of consecutive terms which they may serve.

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Erie County Charter

Section 1303. Advisory board. The County Executive shall appoint a mental health advisory board which shall, at the request of the Commissioner, and may on its own initiative, advise on matters relating to an adequate program of mental health services in the County. The composition of such board in regard to the number of members and the professional, governmental or other representation, and the terms of such members, shall be as provided in the Mental Hygiene Law for the Community Mental Health Board.

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Chemung County Charter

Section 701. Department of Mental Health; Director; Appointment; Qualifications. There shall be a Department of Mental Health, headed by a Director, who shall be appointed by the Mental Health Board subject to confirmation by the County Legislature, and shall serve at the pleasure of the Mental Health Board.
Section 703. Mental Health Board. There shall be in the Department a Mental Health Board. The Chairman of the County Legislature shall be a member of this Board, or a County Legislator as designated by the Chairman of the County Legislature. The members of the Mental Health Board shall be appointed in the manner provided by the Mental Hygiene Law, and shall consist of such members and terms as conferred by the Mental Hygiene Law or any other applicable law or regulations, and the terms of said members should be of such duration as provided by the Mental Hygiene Law or any other applicable law or regulation.

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Ulster County Charter

C-44. There shall be a Department of Mental Health, headed by a Commissioner of Mental Health. The Commissioner of Mental Health shall be experienced in public mental health administration and meet the qualifications for this position as specified in the New York State Mental Hygiene Law and/or by the State Commissioner of Mental Hygiene. He or she shall be appointed by the County Executive in consultation with the Community Services Board and with confirmation by the County Legislature and serve at his or her pleasure.

C-45. There shall be a Community Services Board of 15 members… The Board shall advise the Commissioner of Mental Health, the County Executive and the Legislature on matters relating to the Department of Mental Health. The members of the Board shall further have the power to inspect and review all facilities and programs of the Department of Mental Health, with or without notice to the Commissioner of Mental Health and may report and make recommendations to the County Executive, County Legislature and Commissioner of Mental Health.

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Tompkins County Charter

- County Administrator appoints Commissioner of Mental Health Services with consultation from the CSB.
- Commissioner responsible to the CSB for implementation of mental health policy in the county.
- Commissioner of Community Mental Health Services is the same as the Director of Community Services in the mental hygiene law.
- The Community Mental Health Services Board has essentially all the policy making powers granted to a Community Services Board in the state mental hygiene law.

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Question: How many people are on the CSB?

Answer: In counties with a population **less than 100,000** - choice of **nine or fifteen members** appointed by the local government. **In the City of NY** the board shall consist of fifteen members appointed by the Mayor. There must be two residents from each of the boroughs. In **all other** local governments **fifteen** members appointed by the local government.

A county with a population of under 100,000 may change the number of board members by local law and effectuate a reduction through attrition as vacancies occur and terms expire (AG opinion)

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Who can be a CSB member?

Whenever practicable

- at least one member shall be a licensed physician and
- one member shall be a certified psychologist and

Outside of NYC-otherwise at least two members shall be licensed physicians.

Members are to have demonstrated an interest in the field of services for the mentally disabled. And shall represent the community interest in all the problems of the mentally disabled and shall include representatives from community agencies for the mentally ill, the mentally retarded and developmentally disabled, and those suffering from alcoholism and substance abuse.

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Can public officials be CSB members?

Yes - a person's public office or employment shall not bar appointment as a member of a board or subcommittee nor shall membership on the CSB serve as a bar to other public office or employment.

- However **no more than three employees of the state department of mental hygiene or of a department facility may be appointed as a member of a CSB or subcommittee.**
- Membership on a community services board does not disqualify a person from also serving as a member of a legislature (provided that such person should not take part in the legislature's decision as to whether to reappoint him or her to the CSB)
- **The chair of a community services board may simultaneously hold the office of member of the county board of representatives**. (1990 N.Y. Op. (Inf.) Att'y Gen. 67; November 7, 1990)

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How Long is a CSB term?

- Each member shall be appointed for a **four-year term**.
- All terms shall begin to run from the first day of the year of the appointment.
- Vacancies shall be filled for unexpired terms.
- No person may serve as a member of a board or a subcommittee for more than two terms consecutively ***unless otherwise provided by local law.***

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Are CSB members paid?

Local governments shall reimburse board members for the reasonable expenses incurred in the performance of their duties

Local Governments may also offer CSB members a per diem compensation, but only reasonable expenses are reimbursable as an operating cost.

CSB members may be reimbursed only for meal expenses incurred:

- where a member is traveling outside of the county or outside of his regular work area on official business for an extended period of time or
- where he is prevented from taking time off for food consumption due to a pressing need to complete the business at hand.

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CSB members may not be reimbursed for their meals even when the board meets at a place where meals are served since there is no compelling reason to convene meetings at such places and the cost of the meal is a burden which the committee members have placed upon themselves.
(1981 Op St Compt File #81-13.)

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How do you remove a CSB member?

Local governments may remove a board or subcommittee member for cause, after written notice of charges and an opportunity for the member to be heard.

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Subcommittees

- Mental health (MH)
- Intellectual and developmental disabilities (I/DD),
- Alcoholism, except that, at the discretion of the local government, a subcommittee for alcoholism and substance abuse (CD) may be substituted for a subcommittee for alcoholism.

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Subcommittees Members

- Subcommittee members are **appointed by the local government**
- The I/DD and CD committees shall have **no more than nine members, and at least 3 must be CSB members**
- **The MH committee** shall have no more than eleven members **at least 3 of whom must be CSB members.** Also at least two members who are or were **consumers** of mental health services, and at least two members who are **parents or relatives** of persons with mental illness.

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All subcommittee members should be persons who have demonstrated an interest in the field of services for the particular class of mental disability.

All subcommittees should include former patients, parents or relatives of such mentally disabled persons and community agencies serving the particular class of mental disability.

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Subcommittee Functions

- Advise the CSB and the DCS regarding policy in their area.
- The subcommittee for mental health shall be authorized to annually evaluate the local services plan and to report on the consistency of such plans with the needs of persons with serious mental illness.

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The Director of Community Services (DCS) 41.09

Duties and powers set forth in Section 41.09 of the Mental Hygiene Law and Part 102 of Part 14 of the New York Code of Rules and Regulations.

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DCS

- **Charter** governments may provide for appointment and removal of directors in a manner authorized by such governments.
- In Non-Charter Counties, the CSB shall appoint and remove the director.
- Salaries and allowable expenses shall be set by the appointing authority.
- **Charter governments may vest policy-making functions in the director or they may vest all or some of such functions in the board.**

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Who May Be a DCS?

- A psychiatrist or other professional person who meets **standards set by the commissioner.**
- If the director is not a physician, he or she must appoint a physician to conduct examinations authorized to be conducted by an examining physician or by a director of community services.
- A director does **NOT** have to reside in the area to be served.
- A director **MUST** be a full-time employee except in cases where the IOCC has expressly waived this requirement.

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What are the Standards set by the Commissioner?

The Commissioner's regulations (§ 102.6) provide that each director of community services appointed on or after the effective date of the regulation shall meet the following requirements:

1. The individual shall be a physician licensed to practice medicine in New York State who shall be deemed board certified or board eligible in psychiatry, neurology, pediatrics, or
2. The individual shall be a psychologist who is currently licensed as a psychologist by the New York State Education Department; or
3. The individual shall have obtained a master's degree in social work, and is currently licensed as a licensed master social worker or as a licensed clinical social worker by the New York Education Department; or

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4. The individual shall have obtained a master's degree in psychiatric mental health nursing and shall be licensed by the New York State Education Department as a registered nurse; or
5. The individual shall have obtained a master's degree in rehabilitation counseling, psychology, social work, public health administration, public administration, hospital administration, human services administration, business administration or other equivalent degrees as determined by a curriculum reviewed and approved by the New York State Education Department; and
6. The individual must have obtained a degree or degrees from a college or university recognized by the New York State Education Department; and

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7. The individual with a doctoral degree or medical degree, or an individual with a master's degree shall have had at least five years of progressively responsible clinical and/or administrative experience in a governmental, private, not-for-profit or proprietary program providing services for people who have a diagnosis of mental illness, mental retardation, developmental disability, alcoholism or substance abuse. At least two of the five years shall include functioning in an administrative capacity for the management of a program in which the candidate was responsible for the overall direction and control of an identifiable organizational unit or program. Such experience shall be specifically related to the powers and duties of the director of community services in accordance with section 102.7 of this Part.

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If DCS has Administrative Degree

When a local governmental unit appoints a director of community services with an administrative degree, the local governmental unit shall **also designate a senior level clinician** with responsibilities for supervision of clinical services. Such designee shall have a clinical degree and licensure or certification in addition to demonstrable clinical work experience.

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Some Specific Duties of DCS

1. Power under MHL 9.37 to hospitalize.
2. Power under MHL 9.45 to transport.
3. Power under MHL 9.46 regarding SAFE ACT reports.
4. Oversight of Assisted Outpatient Treatment (AOT) program.
5. Power under MHL 22.09 to transport person incapacitated by alcohol or substances.
6. Duty under CPL 7.30 to appoint examiners to determine capacity to stand trial. (Family Court Act 251)

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NYS Conference of Local Mental Hygiene Directors

§ 41.10 of the Mental Hygiene law creates a statutory organization to be known as the State Conference of Local Mental Hygiene Directors and to be referred to as The Conference.

Its members are all the Directors of Community Services in the City of New York and the 57 other counties.

The conference is required to meet twice a year, or when called by the chairman, provided ten days' notice is given.

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Powers of the Conference

The Conference has the power to adopt, amend or repeal by-laws relating to its business and the conduct of its affairs. It also has the following powers:

- To review and comment upon rules or regulations proposed by any of the offices of the department for the operation of local and unified service plans and programs.
- To propose rules or regulations governing the operation of the local and unified services programs, and to forward such proposed rules or regulations to the appropriate commissioner or commissioners for review and consideration.

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The Role of the Conference

According to § 41.04 of the MHL, the Conference is the **spokesperson for the counties** with the commissioners of the offices of the department.

By law, the commissioners of the offices in the department are required:

- to consult and cooperate with one another
- **to meet from time to time with the New York State Conference of Local Mental Hygiene Directors**, to ensure that the procedural policies, rules and regulations governing the planning and financing of the care, treatment and rehabilitation of the mentally disabled adopted by each of the offices in the department are consistent with one another.

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How are programs authorized?

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OMH Program Licensing

14 NYCRR Part 551.

Three main levels of program approval review, with non-exhaustive examples:

1. Comprehensive Prior Approval Review (PAR): E.g., new provider opening licensed program, new IP (inpatient) program, IP closure or significant expansion/reduction in beds, change of sponsor when new provider, etc.
2. EZ PAR: E.g., new or closure of OP (outpatient) program or satellite, relocation of OP program out of county, moderate IP or OP expansion/reduction, CR (community residence) capacity change, etc.
3. Administrative Action (AA): E.g., relocation of OP program within county, minor capacity expansion/reduction, satellite to full conversion, incorporation papers, etc.

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LGU Role Differs by Type of Review

1. Full Review (PAR):
   - LGU support required
   - Applicant required to consult with LGU prior to submission to OMH
   - LGU comments and conditions for approval incorporated into OMH and BHSAC review
2. EZ PAR
   - LGU letter of support required in EZ PAR submission prior to review by OMH (except when LGU is the provider applicant)
   - LGU may also comment on application after submission during 10 day review period (in Mental Health Provider Data Exchange (MHPD))
3. Administrative Action (AA):
   - No formal LGU role
   - LGU notified via MHPD and may comment, or field office may request comment by LGU

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OASAS Certified Program Planning

14 NYCRR Part 810

Three types of program approval review with examples:

1. Certification Application requiring Full Review: E.g., new provider opening certified program, new sponsor (not known to OASAS), change in ownership of 10% or more, capital project.
2. Certification Application requiring Administrative Review: E.g., new treatment service (existing provider), relocation, capacity increase, space expansion, new additional location for outpatient services, transfer of ownership
3. Certification Application not requiring a prior-consultation: E.g., minor relocation, changes to supportive living sites, changes to prevention counseling locations.

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LGU Role Differs by Type of Review

1. Full Review
   - Applicant required to have a Prior Consultation with LGU and OASAS Regional Office
   - Formal LGU recommendation (PPD-6) requested as part of review
   - LGU comments and recommendation incorporated into OASAS and BHSAC review
2. Administrative Review
   - Applicant required to have a Prior Consultation with LGU and OASAS Regional Office
   - Formal LGU recommendation (PPD-6) requested as part of review
   - LGU comments and recommendation incorporated into OASAS review
3. Certification Application not requiring a prior-consultation:
   - Applicant required to get LGU and OASAS Regional Office signature on application indicating support and approval.

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How are Programs funded ?

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Program Funding Methods

- **State Aid Letter (SAL) – OMH / State Aid Funding Authorization (SAFA) - OASAS**
  - OMH and OASAS provide Net Deficit Funding, quarterly, to cover county expenses after all other revenue sources are exhausted. Contracted and managed by the county (LGU).
- **Direct Contract**
  - Providers receive a direct contract from OMH and OASAS for services within a county.
- **Public & Private Insurance**
  - Medicaid, Medicare, CHIP, Tricare, commercial insurance.
  - Programs that provide Medicaid-eligible services can bill for services provided and receive Medicaid funding. Paid through either Fee-for-Service or Managed Care.
- **County Funds**
  - County can choose to provide funding to programs using county resources/tax dollars.
- **Other**
  - Self pay, program fundraising, legislative and other grants.

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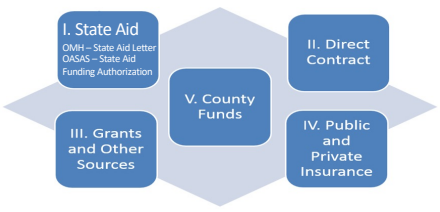
Local Program Funding Sources



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Transformation & influences in the MH system

- **Mental health and physical health impact each other in outcomes and cost** – integrated approach is necessary
- **Social Determinants are real.**
  - Poverty, homelessness, food insecurity, unsafe neighborhoods
- People w/mental illness and/or SUD comprise a **significant percentage of the homeless population**
- People w/MI and/or SUD are **overrepresented in the criminal justice system & county jails**

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Transformation & influences in the MH system

- **Growing influence of Managed Care in the Medicaid program.**
  - Integration of physical health & behavioral health – treat the whole person.
  - Goals to improve continuity of care and improve outcome and reduce costs.
  - Value based payments
- **Impact of the changes in the Criminal Justice system.**
  - The CPL 730 problem- A8402A/S7461A
  - Impact of Bail Reform

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The LGU Role in System Change

LGU – has a better overview of the mental hygiene system & how each component supports/impacts others

LGU has linkages across other community systems that no one else has.

- Hospitals & MH/SUD clinics
- Primary Care & Pediatric Clinics
- Adult & Children's SPOA
- LSSA
- Law enforcement, jail clinical staff, court system
- -State PCs and ATCs
- -Housing & Shelters
- -Crisis response services
- -Peer support

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It is all about Medicaid

- Medicaid has become the largest funder of behavioral health services.
- NYS relies heavily on Medicaid funding in Public BH system.
- Currently Federal Government pays 50% of the cost of Medicaid.
  - State and local governments share balance with State paying about 34% and the local share about 16%. Local Share is capped.
- NY Covers adults 21-65 under its State Plan. Allowed by ACA.
- MRT- Medicaid Redesign Team- Used to develop first year Cuomo MA budget proposal and develop a multiyear reform plan.

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It is still all about Medicaid

- State Plan- (State Plan Amendments (SPA) – Amendment to plan that CMS requires every state to have in order to get Federal share.
- 1115- Demonstration waivers- allows bending MA rules for demonstrations.
- 1915(b) waivers- allows waiver of freedom of choice requirement to permit managed care plans.
- 1915 (c) waiver- waives comparability requirement to allow HCBS including non-medical services.

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Other Medicaid Terms

- **Medicaid managed care** and **Value Based Payments**
  - MCOs- Managed Care Organizations
- **Home and Community Based Services (HCBS)-** services for people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting. E.g., case management, home health aides Day programs etc.

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- **Community Oriented Recovery and Empowerment Services (CORE)**
  - 1115 waiver in NY replaces HCBS.
  - Includes such services as Community Psychiatric Support and Treatment (CPST) • Psychosocial Rehabilitation (PSR) • Family Support and Training (FST) • Empowerment Services • Peer Support.
- **HARP- Health and Recovery plans**
  - manages care for adults with significant behavioral health needs. .
  - facilitate the integration of physical health, mental health, and substance use services for individuals requiring specialized approaches.

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CPL. § 730

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§ 730.10 Definitions

- "**Incapacitated person**" means a defendant who as a result of mental disease or defect lacks capacity to understand the proceedings against him or to assist in his own defense.
- "**Order of examination**" the order from a court to an appropriate director to arrange for a psychiatric exam to determine capacity.
- "**Director**" means
  a) the director of a **state hospital** operated by OMH or OPWDD, or
  b) the director of a hospital operated by a **local government**, or
  c) the director of **community mental health services** (**3rd Choice**).
- "**Psychiatric examiner**" means a qualified psychiatrist or a certified psychologist **who has been designated by a director.**

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730.20- Location of Examination.

1. Where the defendant is being held in custody.
2. In the community.
3. In the Hospital.
   - confinement can be for **up to 30 days**
   - Subject to **court ordered extension of another 30 days**.
   - During such confinement, the hospital can "administer such emergency psychiatric, medical or other therapeutic treatment as in his judgment should be administered".

Molinaro v. Warden, Rikers Island- Court of Appeals

when a defendant is not in custody, a court has only the authority to either order a competency examination on an out-patient basis or to direct that the defendant be confined in a hospital pending completion of the examination upon proper medical recommendation that such confinement is necessary.

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CPL § 730.50 Fitness to Proceed

If the **superior court** determines that the defendant is not an incapacitated person, the criminal action against him or her must proceed.

If it is satisfied that the defendant is an incapacitated person, it must adjudicate him or her an incapacitated person and must issue a final order of observation or an order of commitment.

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Jackson v. Indiana

US Supreme Court (1972)

- Mentally defective deaf mute with the mental level of a preschool child.
- Aged 27 accused of two robbery charges of a total of nine dollars.
- Trial court found him incompetent to stand trial and committed him the Indiana Dept of Mental Health.
- His attorney alleged that since his improvement was so unlikely, it amounted to a life sentence in the absence of a conviction in violation of due process and equal protection right as well as being cruel and unusual punishment.
- Court said that the defendant "**could not be held more than the reasonable amount of time necessary to determine whether there is a substantial probability that he will attain competency in the foreseeable future**…"
- If not, the state had to begin civil commitment proceedings or release the defendant.

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MHL § 43.03 (c). Liability for fees.

County Responsibility for Payment for Restoration Services

- "Patients receiving services while being held pursuant to order of a **criminal** court… or for examination pursuant to the order of the **family court** shall not be liable to the department for such services.
- Fees due the department for such services shall be paid by the county in which such court is located.
- Except that counties shall not be responsible for the cost of services rendered patients committed to the department pursuant to CPL 330.20 (not responsible due to mental disease or defect) or MHL Article 10 (sex offenders)."

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County Responsibility for Payment for Restoration Services

- Predates the unification of the Court System when Counties ran and paid for the criminal court system. Now the state pays for the entire unified system.
- Prior to April 2020- Both OMH and OPWDD only passed on 50% of this charge to the County. Probably a remnant of the old 50-50 state county split of all mental hygiene costs which existed under the old net deficit financing system.
- The 2020 budget changed this and was passed with the provision that counties would now pay the full 100% of the cost of OMH restoration. OPWDD restoration is still charged at approximately 50%.
- Fees for Restoration are approximately $1,300.00 per day.

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We need to address these concerns

- **We need to find a way to be more critical concerning how 730 is utilized.**
- **There are cases where defendants have stayed for 5 or in one case almost 10 years. At current rates it would cost $3,650,000 just to get someone ready to be tried.**
- **Often cases of restored defendants are then pled down to a misdemeanor. Had the original charge been a misdemeanor the treatment would not have been charged to the county**
- **Judges often will sign a 730 order under the assumption that they are sending the defendant for needed mental health treatment… This is not correct. Restoration is not treatment.**
- **It is difficult, if not impossible to budget for restoration expenses as it will depend on who allegedly commits crimes in your county and what is state of their mental health.**
- **It is the county where the committing court is located that pays, not the county of residence of the defendant.**
- **If a mentally ill person is hospitalized under Article 9 of the Mental Hygiene Law, the state absorbs the entire cost and cannot charge the cost back to the County.**

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Some Possible Solutions

OUTREACH

- **Education**- Education of all stakeholders- judges, court clerks, DAs, elected officials, defense attorneys, law enforcement etc. about what restoration treatment is and what it costs to the county taxpayer may be helpful to reduce inappropriate use of this procedure. A community wide effort is needed.
- **Communication**- All departments of the County need to work together to find the right solution for your county and to communicate with OMH and OPWDD to assure that restoration services are not overused.
- **More thoughtful charging**- If law enforcement has a place to take a mentally ill person, they may not have to bring charges. (Crisis Stabilization Services) If a DA is willing to reduce charges to a misdemeanor, the county will not be charged for the treatment.
- **Outpatient restoration**- needs the consent of the DA

DIVERSION

- **Sequential intercept**
- **Specialty Courts**
- **Treatment not Jail**
- **Outpatient treatment funded by MA**
- **Civil Commitment proceedings.**

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Highlights of Proposed 730 bill

- Makes it clear that restoration is not mental health treatment.
- Requires OMH and OPWDD to set standard for competency examinations.
- Requires examiners and courts to find restoration reasonably possible. (Jackson v. Indiana).
- Fees for examiners can be contracted by county or are set by the court.
- Requires court review and then allows switch to Article 9/15 placements.
- Deletes sections of law that have been declared unconstitutional.
- Credit for time served in Article 9 or Article 15 facility.
- Allows a method to convert to a civil proceeding if restoration not likely or not achieved.
- Allows for Medicaid participation when available.
- Makes it clear that counties are not to pay for 508 services.
- Requires reinvestment of local dollars saved into community mental health.

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Questions?

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