

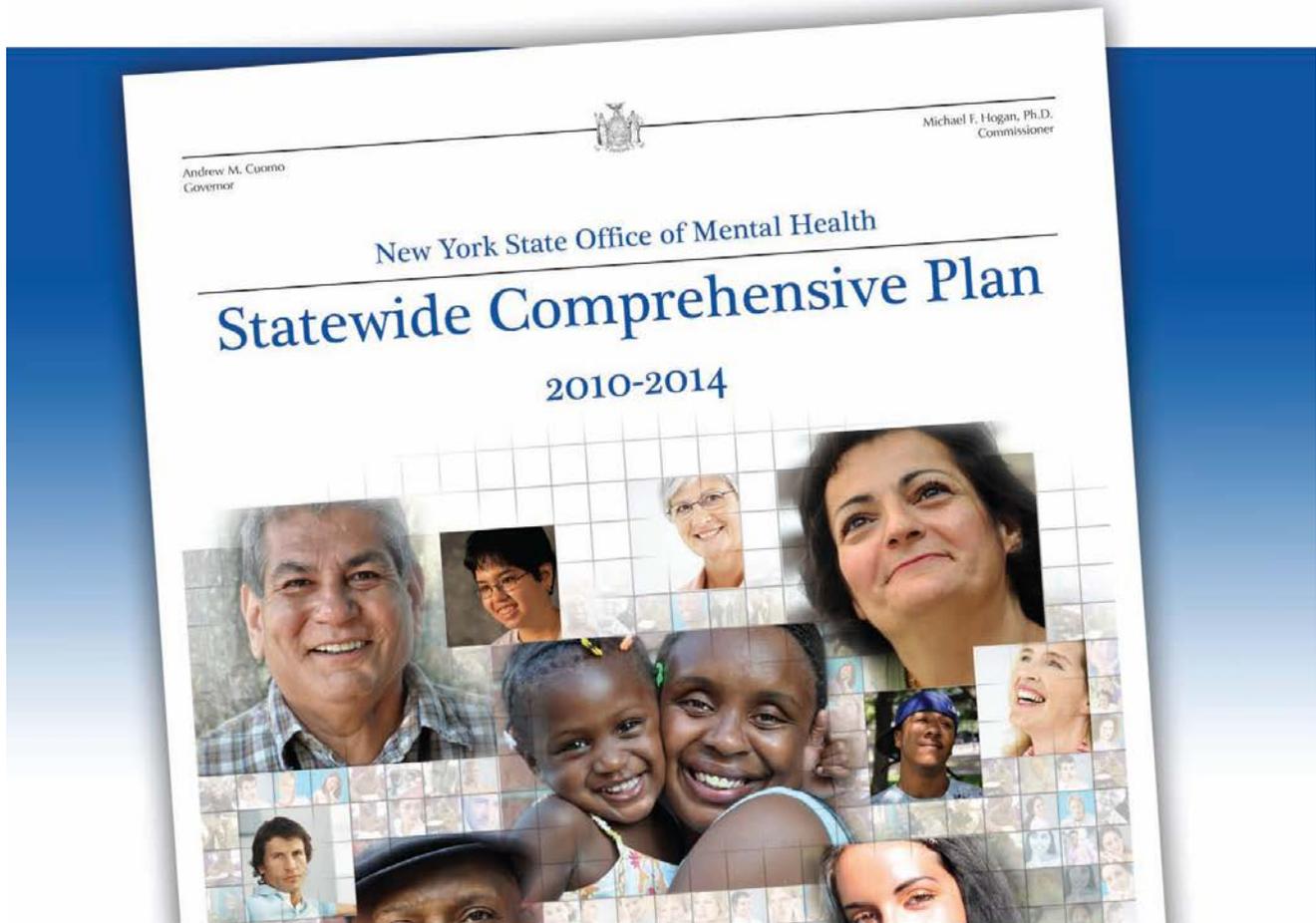
Andrew M. Cuomo
Governor



Michael F. Hogan, Ph.D.
Commissioner

New York State Office of Mental Health

2011 Interim Report



New York State
omh
Office of Mental Health

February 15, 2011



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*Statewide Comprehensive Plan
for Mental Health Services 2010–2014*

February 15, 2011

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A Message from the Commissioner

This *Interim Report* concentrates largely on progress since the October 1, 2010 publication of the *Statewide Comprehensive Plan*. While capturing advancements in major strategic areas over the past six months, it does not focus on the forecast for New York's mental health system nor does it delve into two major developments that will affect almost everyone who receives services or works in the vast public mental health system. Both of these developments—the redesign of Medicaid and the most challenging budget in years—will force change, upset the status quo, and compel us to think hard about priorities. With nowhere to hide from these realities, our best course is to engage, adjust and adapt.

The Medicaid Redesign effort grows from the reality that New York spends far more on Medicaid than any other state—without getting better results. This fact affects the mental health system directed by the Office of Mental Health (OMH) because, as in other states, New York uses Medicaid to pay for almost all mental health care, even that for which the State once had pure responsibility. So changes in Medicaid mean changes in mental health care. And, the only crystal clear direction for Medicaid redesign is less spending.

New York's specialty mental health system coordinated by OMH has required a large safety net primarily because of the systematic failure to address mental health problems in the general health system—the place where almost everyone goes first when they are looking for some help. The data show that although the average age of first mental health symptoms is 13, the average delay until getting care is 9 years. Moreover, only about half of all physicians report they are comfortable with diagnosing and treating depression, the most common and reliably diagnosed mental illness. Weakness in mental health care exists across the general health system from primary care to health plans.

Despite what appears to be a gloomy picture, we do see a positive direction. Assuming health reform is not rolled back, almost everyone in America will eventually have health insurance, and essentially all insurance will include parity for mental health care. This is good. In the short term, however, we face the difficult challenge of advocating for improved mental health care in the overall health system—and especially for children—when we know there is little chance to expand anything. We do see an opportunity to improve the coordination of mental health care, particularly for people who use high amounts of emergency and inpatient care, because they do not have a good overall plan of care. Better care coordination is crucial. The delivery of effective care coordination by specialists in mental health care (known as managed behavioral health organizations), rather than by regular health plans that lack a good track record and experience with mental health, is essential.



In terms of the State budget, we face even more difficult times than in the past few years. During this period, as noted in this *Interim Report*, OMH continues to create efficiencies, reduce costs, and maintain quality care. By increasing admissions to our inpatient programs, we have improved access while decreasing capacity and reducing costs. With staffing declines, we have maintained community capacity. Further reductions in OMH inpatient capacity may be required. Whatever challenges we face, we will remain faithful to our mandate to provide safe, quality care as measured by accreditation standards and reviews.

As OMH engages, adjusts and adapts, its strategic directions will evolve, consistent with the principles of recovery and resilience, in collaboration with shareholders and local governmental units, and be reflected in future Statewide Comprehensive Plans. In all, we are resolved to emerge from all of these challenges as the best and most substantial State mental health program in the country.

Michael F. Hogan, PhD
Commissioner



Chapter 1

Recovery, Resiliency and Transformation Challenges

This *Interim Report* is an update to the *Statewide Comprehensive Plan for Mental Health Services* published in October 2010. Chapter 1 provides an overview of progress on initiatives that advance the agency's core mission. Chapter 2 provides an update on the collaborations that support safe, integrated, quality care. Chapter 3 provides highlights from Governor Cuomo's 2011–2012 Executive Budget and its anticipated impact on the Office of Mental Health (OMH). Chapter 4 summarizes key legislative actions from the 2010 legislative year.

Common, widespread and disabling, mental illness affects more than 1 in 5 New Yorkers each year. Mental health challenges seriously impact day-to-day school, work, and family functioning for 1 out of 10 adults and children. To the surprise of many, the disease burden or total cost of mental illness exceeds that caused by all cancers. An estimated 6 out of 10 people do not receive care for mental health problems, and for the majority of people in New York who do seek treatment, they obtain it in programs not operated, funded, or regulated by OMH. They often see private therapists, rely on self-help and peer support, or receive medication treatment from their primary care physicians. People living with complex and disabling mental illness or lacking adequate insurance coverage, however, require more. This is where the OMH safety net is essential.

The core mission of OMH is to sustain the public mental health safety net of nonprofits, county and State hospitals and outpatient programs for adults living with serious mental illness and children and youth with serious emotional disturbance. This mission is important, particularly in tough fiscal times when rates of mental illness and suicide increase and private care is less accessible.

The *Statewide Comprehensive Plan for Mental Health Services* outlines two major strategic directions to meet the mission of sustaining essential public mental health safety net services:

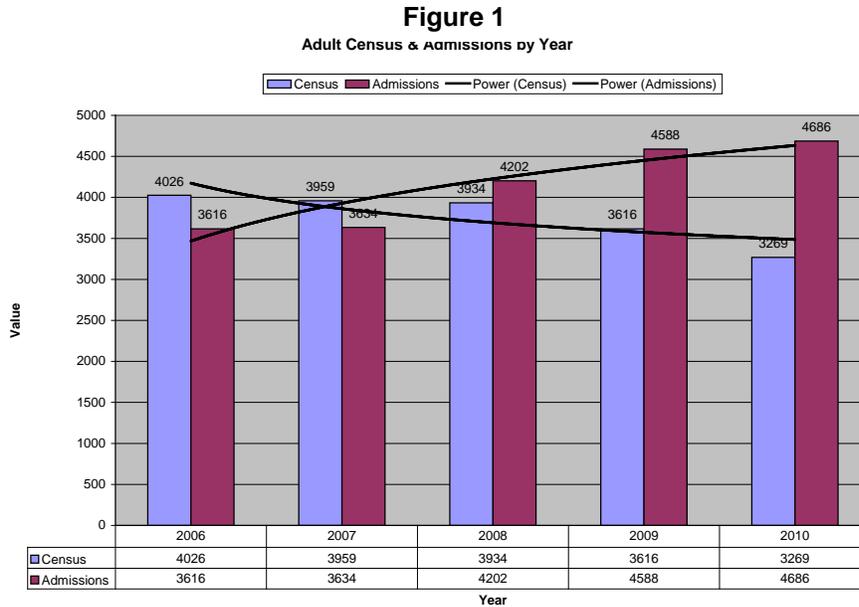
1. Maintaining recovery-oriented quality and access in State-operated hospitals and outpatient programs, including those serving inmates in Department of Correctional Services prisons
2. Fostering reform and safeguarding outpatient clinic services in local governmental units, including Medicaid support; converting other outpatient programs to the Personalized Recovery-Oriented Service (PROS) model; and preserving housing programs that provide a foundation for stable living and recovery

Helping people recover from serious illness and lead meaningful, productive lives in their communities is imperative at any time, but especially when economic resources are limited. OMH is focused on improving access to acute hospital services, reforming mental health clinic financing, enhancing workforce productivity, strengthening care coordination, and fostering individual recovery and resiliency.



Improved Productivity and Focus of OMH Hospitals

As illustrated in Figure 1, OMH has made substantial gains since 2008 to improve the efficiency and productivity of its hospitals and increase access to acute care. During 2010, adult hospitals admitted 4,686 individuals into about 3,380 beds, representing 484 more admissions than in 2008, an increase of 11.5% (and of 29% over the 3,634 admissions in 2007). These gains continue to occur with fewer beds and with sizeable reductions in overtime among staff.



This progress results in part from the Transitional Placement Program initiated in fiscal year 2010–11. The program aids persons who have received maximum benefit from inpatient treatment to move into their communities with appropriate outpatient treatment and supports. The number of people with hospital stays of greater than one year has dropped from 1,732 on September 30, 2007, to 1,181 on September 30, 2010.

Between 2007 and 2010, direct admissions increased 45%, representing success in shifting to a more short-stay, acute care model for OMH inpatient services.

Despite challenges to sustaining quality, Joint Commission surveys conducted in 17 OMH hospitals in 2010 demonstrate that OMH performance and outcomes met or exceeded the national average in most of the quality standards reviewed.

Continuing Reform of Mental Health Clinic Financing

In October 2010, OMH began its multiyear Clinic and Ambulatory Restructuring initiative to restructure the delivery and reimbursement of publicly supported mental health services. Clinic reform aligns financing with quality expectations, ensures consistency and compliance with federal billing requirements, reduces vulnerability under Medicaid requirements, and improves access to treatments and services that enable people to move on with their lives. Clinic restructuring involves five key components, including a redefined and more responsive set of clinic treatment services and greater accountability for outcomes; increased, consistent Medicaid clinic rates and phase out of the Comprehensive Outpatient Program Services method; a procedure-based payment system compliant with the Health Insurance Portability and Accountability Act; managed care underpayments; and indigent care provisions.



The transition to a new clinic system is not a simple process, given the complexity of financing mechanisms and regulation that have grown through the years. The Centers for Medicare and Medicaid Services (CMS), for example, has not yet approved the amendment to the State Medicaid Plan for OMH-licensed mental health clinics. As a result, while Part 599 of New York Codes and Regulation went into effect on October 1, 2010, mental health clinics are unable to transition to Ambulatory Patient Group (APG) claiming until CMS approval has been received.

To ensure smooth implementation of clinic restructuring, OMH makes available materials on specific topics (e.g., the clinical model, Part 599 clinic regulations overview) on the [Clinic Restructuring](#) section of the OMH website. Additionally, OMH staff monitors the claims process and provides technical billing assistance, where indicated. A shareholder group is designing an evaluation for monitoring patterns of care and identifying areas for improvement.

Addressing Treatment and Services Priorities

The Well-Being of Children and Families

- *The Children's Plan*

A 2009 amendment to the *Children's Mental Health Act of 2006* formalized the involvement of nine State child-caring agencies and family and youth partners in implementing the recommendations of the *Children's Plan of 2008*. The amendment placed the coordinating function of specific recommendations in the Plan within the Council on Children and Families (CCF). The Plan goals are to strengthen child and family resilience and reverse patterns of maltreatment, neglect, school expulsion, academic failure, violence, substance use, institutionalization and premature death.

In 2010, regional youth partners were hired to serve as cross-system peer support specialists to promote Plan initiatives and ensure youth input. And, over the last year, the platform for communicating information about the *Children's Plan* has been strengthened. (See the ["Engage" web site](#)  at for the most up-to-date information on Plan activities.)

- *Children's Ambulatory Restructuring Project*

As adult ambulatory restructuring is under way, similar work is taking place under the OMH Child and Family Ambulatory Reform Project, which has been examining strategies to control costs while maintaining quality treatment and supports for children with serious emotional disturbances and their families. While these children have complex needs and are often served in multiple systems (e.g., juvenile justice, education), the children and families are better served when treatment is coordinated and integrated across such systems. Program and fiscal recommendations were finalized late in 2010 and are currently under review by the OMH Division of Children and Family Services staff in consultation with national experts.

Better Outcomes with Care Coordination and a Focus on Wellness

People living with serious mental illness who develop health problems experience significant challenges. The complexity of their conditions sometimes results in the experience of fragmented care that puts them at even greater risk of poor health outcomes. For these reasons, care coordination is a priority for OMH.

- *Intensive Monitoring of Care*

In the wake of several highly publicized violent incidents involving individuals with mental illnesses, a New York State and City panel in 2008 examined cases, considered expert opinions, and recommended actions to improve care and public safety. The New York City Mental Health Care Monitoring Initiative (CMI) has identified risk groups for screening, created a data system to flag gaps in services (called “alerts”), and launched two borough care monitoring teams in Brooklyn and the Bronx.

CMI findings confirm that no system is in place to coordinate care across agencies or to engage people with the greatest needs and most complicated conditions who have dropped out or been lost to care. More telling, CMI data from just one month underscore the need to move from monitoring care to actually rolling up our sleeves, digging in, and expertly managing care in our communities. During August 2010, 40% of people triggering CMI alerts were enrolled in more than a dozen plans operated by 10 Medicaid managed care organizations, and one-half of these individuals were in plans structured to provide full-benefit medical and mental health services. (For more information on lessons learned from CMI, see [Patient Care: Managing High Need, High Cost Medical Patients](#). )

Growing evidence in New York and nationally indicates that substantial savings and improvements in health are possible for people who have the highest needs and are the most costly to serve. Such savings and better health have been achieved with behavioral managed care organizations that have strong track records in care management for people with serious psychiatric disabilities, oversee and develop integrated services networks, offer peer services, use assertive engagement for the highest cost cases, and improve accountability through effectively managed contracts.

- *Coordination of Care Consortium*

The New York Care Coordination Program is a seven-county consortium that serves approximately 2,800 persons with severe mental illness. The program helps people meet life goals, achieve recovery, and live successfully in the community. Begun in the late 1990s, a group of six counties in the western part of New York (Erie, Monroe, Onondaga, Chautauqua, Wyoming, and Genesee) agreed to collaborate on a managed care approach to care. In 2010, Westchester County became the seventh county to join.

The care coordination program pursues complex care management for people who have intensive mental, physical and chemical dependency needs, have inadequate support networks and do not participate fully in community life. Care coordinators help arrange for services and supports, ensure they are being provided as outlined in each person’s individualized care plan, assist in obtaining and maintaining housing and other public assistance benefits, and promote wellness.

While producing significant cost savings, the care coordination program has also improved quality of care. Six-month interval measures for people participating in care coordination show that in 2009 the percentage reporting gainful activity and competitive employment were



up by 31% and 51%, respectively, while arrests dropped by 25%. The analysis also found a decline of 46% in emergency department visits and 53% in psychiatric/general hospital inpatient days. A 2008 study showed that costs for inpatient mental health care in the six participating counties were 92% lower than in a comparison county group. For more information, go to the [Agency for Healthcare Research and Quality Innovations Exchange](#). 

- *Improved Prescribing Practices and Enhanced Health Monitoring*

In partnership with the State Department of Health (DOH), OMH has implemented the Psychiatric Clinical Knowledge Exchange System (PSYCKES) continuous quality improvement initiative in 330 community outpatient clinics. PSYCKES enables clinics to reduce the prevalence of multiple psychotropic medication use and antipsychotic use for persons with higher risks of metabolic side effects in the presence of existing cardiometabolic conditions.

Among participating clinics, the prevalence of multiple psychotropic medication use from March 2009 to September 2010 declined by 10.7% compared to the nonparticipating clinic group, which showed a rise of 1.1% during the same period. The prevalence of the use of antipsychotics with higher risks of metabolic side effects in the presence of existing cardiometabolic conditions decreased for participating and comparison clinics, but the trend was more pronounced for participating clinics (12.6% decrease) than for comparison clinics (2.5% decrease). OMH also formed a quality partnership with the Greater New York Hospital Association in which 20 hospital outpatient clinics will use PSYCKES to decrease cardiometabolic risk.

All OMH-operated adult clinic services regularly monitor three indicators of physical health and medical risk—smoking status, body mass index (BMI) and blood pressure. In addition to these indicators, adults hospitalized in OMH psychiatric centers are tested for cholesterol, lipids and fasting blood sugar. OMH-operated child and youth clinics and day treatment programs measure quarterly BMI, activity levels, and in youth 13 and over, cigarette smoking, and alcohol and drug abuse. Persons identified as being at risk are receiving tailored interventions (e.g., diet and nutrition counseling, improved coordination with medical providers). Additionally, as part of a new initiative with the New York Collaborative for Wellness and Smoking Cessation, OMH has set a goal of a 10% reduction in smoking among people with serious mental illness.

Supporting Stable Community Living

Reducing reliance on more costly traditional mental health housing models and improving the supply of supportive housing remain top priorities. OMH works closely with State housing agencies, providers of housing services and stakeholders to evaluate and convert, where possible, staffed housing programs to integrated mixed housing settings, supported housing, and treatment apartments.

OMH is also responding to the court decision that requires adults with mental illness living in one of 28 adult homes in New York City to be offered the opportunity to move to supported housing in the community. Following the release of a request for proposals in 2010, OMH in late January announced eight recipients of funding for the development and operation of supported housing for adults living in one of the 28 identified adult homes. The funds will support three phases for the



development and operation of up to 4,500 units of supported housing at the rate of 1,500 units per phase.

Toward Recovery, Resiliency and Transformation

Recovery, resiliency, and transformation serve as the basis for mental health services reforms in New York State.

- ***New York Makes Work Pay***

CMS awarded the State funding in 2008 under a Medicaid Infrastructure Grant for developing infrastructure to support competitive employment opportunities and outcomes for people with disabilities. These funds support the [New York Makes Work Pay](#) program, a series of initiatives spearheaded by OMH, in partnership with Cornell University's Employment and Disability Institute and Syracuse University's Burton Blatt Institute, on behalf of 12 state agencies that come into contact with individuals with disabilities seeking employment opportunities or employment-related supports.

A priority for New York Makes Work Pay is the development of a comprehensive and integrated cross-agency employment services data system that gives job seekers immediate access to job opportunities and makes enhancements that will allow providers to more readily employ people with disabilities. A target date of June 2011 has been set to have the redesigned system available throughout most of OMH, as well as several other agencies.

- ***Personalized Recovery Oriented Services (PROS)***

PROS is a complete recovery program that brings together rehabilitation, support and clinical services into one plan that supports a person's goals for a better life. Growth in the PROS program has been substantial. Between December 2009 and December 2010, PROS programs more than doubled from 22 to 53 statewide. The success of PROS may in part reflect its focus on addressing two major challenges faced by many New Yorkers working to recover from mental illness: (1) It fills the void for care that promotes recovery and choice, both highly valued by people who seek treatment and support, and (2) it helps to coordinate and unify care that historically has been fragmented.

- ***Peer Recovery Technical Assistance and Recovery Centers***

Through targeted investment, modest federal grant funding and active stakeholder participation, OMH has designated a technical assistance center this year to assist local peer programs to evolve into full-fledged Recovery Centers. Through a request for proposal process, OMH selected the University of Medicine and Dentistry of New Jersey School of Health Related Professions to create an online curriculum that will allow Recovery Centers to increase peer-run organization staff competencies, enhance leadership and business management capabilities, and enable peer-run organizations to offer recovery-oriented evidenced-based services.

As health care reforms move forward nationally, it is expected that the visibility of peer Recovery Centers will heighten as they provide expertise to health homes and assist with the coordination and integration of care across systems.

Chapter 2

Interagency Coordination and Collaboration

In addition to the ongoing OMH and Department of Health (DOH) collaboration to restructure and reform financing and services, OMH has a number of other interagency partnerships where progress is taking place. Major initiatives are highlighted here.

Mental Hygiene Planning Committee

Using feedback from county planners participating in the Conference of Local Mental Hygiene Directors/Mental Hygiene Planning Committee, OMH continues to make local planning data more valuable and accessible to counties. Since the introduction of its [County Mental Health Profiles Portal](#) in December 2009, OMH has added consolidated, at-a-glance, and comparative views of key county community characteristics, mental health adult Medicaid services expenditures, and outcomes. Additional data reports under development include county mental health Medicaid utilization summary profiles that include people with substance abuse disorders; children's data to the Medicaid expenditures report as well as other key outcome indicators; forensics indicators (e.g., Medication Grant Program utilization data); adult case management information; and Medicaid managed care data.

Most Integrated Setting Coordinating Council (MISCC)

A body composed of State agency and appointed public representatives, the MISCC is responsible for ensuring that people of all ages with physical and mental disabilities receive care and services in the most integrated settings appropriate to their individual needs. On December 31, 2010, the MISCC published a [two-year plan](#) to gather baseline data and create measurable housing, employment, transportation and long-term care measures that will aid New Yorkers with disabilities to live in the most integrated settings.

New York State Clinical Records Initiative (NYSCRI)

Started in 2009, NYSCRI represents a joint effort of the OMH Long Island Field Office, Office of Alcoholism and Substance Abuse Services (OASAS) Regional Office, and the Long Island Coalition of Behavioral Health Providers. Together, group members have created and are utilizing a recovery-oriented standardized set of medical record forms that comply with the State, federal and accrediting agency standards and regulations. The forms also support medical necessity documentation requirements and they interface with electronic health record formats. Implementation of the records system, which is expected to be very beneficial to providers, is voluntary and being rolled out regionally among invited providers.



OMH and OASAS Collaborations

Two complementary training and technical assistance initiatives currently support the OMH–OASAS partnership to improve services for individuals with co-occurring mental health and substance use disorders.

Through a grant award from the New York State Health Foundation, the first initiative involves the provision of on-site training and technical assistance to OMH and OASAS outpatient clinics through the [Center for Excellence in Integrated Care](#), established by the National Development and Research Institutes. The Center works to strengthen screening, assessment and use of evidence-based practices and improve provider capabilities to serve people with co-occurring problems. It promotes a regional leadership forum to facilitate integrated treatment, supports peer-learning collaboratives, and involves staff in evaluating progress and outcomes.

The second initiative, developed by the Center for Practice Innovations (formerly the Evidence-Based Practices Technical Assistance Center) of the New York State Psychiatric Institute/Columbia University, involves innovative web-based co-occurring disorders education, skills training, and distance learning support for OMH and OASAS providers. The web-based learning modules that make up the [Focus on Integrated Treatment curriculum](#) promote self-paced learning, assist clinicians in improving current knowledge of integrated treatment, strengthen assessment and treatment skills, and enhance knowledge of critical treatment and support services (e.g., supported employment and relapse prevention). Modules are also targeted to clinical supervisors and directors so they may effectively promote integrated care and use outcome data to monitor progress. To date more than 1,000 providers have availed themselves of the curriculum.

Criminal Justice Collaborations

Collaborations help to ensure quality care for persons who are incarcerated and have serious mental illness and they improve community responses to people with mental illness who have contact with the criminal justice system. As noted in previous Interim Reports, partners include the State Division of Criminal Justice Services, the Department of Correctional Services, and Division of Parole. Private partnerships also are also crucial. In 2010, the Center for Urban Community Services in New York City received recognition for its Reentry Coordination System, a federally funded “Projects for Assistance in Transition from Homelessness” (PATH) initiative administered by the Center for OMH. The award acknowledged exemplary practice by the Center, which since 2009, has been using its Reentry Coordination System to gain access to supportive housing units in the City for individuals being released from prison with mental illness and who would otherwise be homeless upon release. During its first year, the system was used to make 420 housing referrals; 79 inmates were placed into permanent housing and 38 were awaiting permanent housing.

Chapter 3

Budgeting and Management in a Fiscal Crisis

While states are under pressure to balance their budgets, they face difficult choices in stressed economic times. Governor Cuomo's 2011–12 Executive Budget seeks to transform the State budget process so that it conforms to fiscal realities and eliminates a \$10 billion deficit, without raising taxes or borrowing. It acknowledges that the State is at a crossroads and calls upon all New Yorkers to work together to address the challenges.

The Budget is designed to rebuild New York, achieve real savings, recalibrate spending to sustainable levels, and restructure the way State government is managed. The Budget recommends actions in almost every area of State spending, includes year-to-year reductions in the two largest drivers of State expenditures—Medicaid and School Aid—and entails reductions and reforms in State government operations. Moreover, it calls for mandate relief at the local level, with a team of stakeholders reviewing mandates that are ineffective, unnecessary, outdated or duplicative and offering recommendations for improved, cost-effective and innovative ways to deliver mandated programs and services locally.

"New York is at a crossroads, and we must seize this opportunity, make hard choices and set our state on a new path toward prosperity. We simply cannot afford to keep spending at our current rate. Just like New York's families and businesses have had to do, New York State must face economic reality. This budget achieves real, year-to-year savings while restructuring the way we manage our state government. This is the first step toward building a new New York."

Governor Andrew M. Cuomo
February 1, 2011

While it presents tough choices and sacrifices, the Budget is intended to bring stability to the State's fiscal condition and open up opportunities for improved services, economic development, and prosperity for New York's citizens. A more efficient government that demands results is a core value underlying the Budget. Specifically, the impact of the proposed Budget on the public mental health system is likely to be felt in two major areas of activity: reducing the size and cost of State government, and reducing unsustainable costs associated with Medicaid while at the same time addressing critical health care needs.

Reducing the Size and Cost of State Government

The Governor's Budget proposal reduces General Fund State Operations spending by 10% at State agencies, primarily by:

- Maximizing savings in non-personal services and working in partnership with State employee labor unions to seek savings in personal service spending in a way that causes the least disruption to State employees while ensuring the continued provision of necessary services for the citizens of New York



- Merging or consolidating separate State entities to streamline and eliminate duplicative bureaucracy, better align State responsibilities with need, and improve services through effective coordination
- Redesigning and transforming government through the work of the Spending and Government Efficiency (SAGE) Commission, which will make recommendations by May 1, 2011 to reduce the number of agencies, authorities, and commissions by 20% over the long term
- Reducing excess capacity in prisons, youth detention and mental hygiene facilities using a task force to examine rational processes (e.g., actions for youth and mental hygiene facilities will be taken following careful analysis of vacancy rates, service utilization, and other factors)

Medicaid Redesign

Medicaid redesign involves an inclusive process by which a Medicaid Redesign Team is developing recommendations for the provision of essential health care services that maintain or improve quality at a lower cost. The proposed Executive Budget reflects a year-to-year All Funds decrease of nearly \$982 million, or 2% in Medicaid spending in 2011–12. The Team is conducting a comprehensive review of the State Medicaid program and making recommendations by March 1, 2011, to close the gap of \$2.85 billion in 2011–12 and a series of other recommendations that lead to measurable improvements in health outcomes, sustainable cost control, and a more efficient administrative structure.

OMH Proposed Executive Budget

The Executive Budget recommends a net decrease of 2.6% for the Office of Mental Health (OMH) during fiscal year 2011–2012. It is a tough and fair budget in light of the State’s fiscal realities. It challenges shareholders of the public mental health system to work together to achieve reasonable savings that help to close the Budget gap, while maintaining quality care.

The current fiscal crisis provides us with the opportunity to draw on our experience from the New York City Mental Health Care Monitoring Project Care to do better with care coordination. OMH is advancing ideas with the Medicaid Redesign Team to establish cost-effective, care management strategies for people with serious mental illness that will ultimately translate into care that creates efficiencies, improves quality and controls costs. These strategies would focus on people who have the highest costs of care and the highest needs, including people with serious mental illness, addictions, and medical conditions as well as the people “lost to care,” those who are underserved and at risk for poor, costly mental health and health outcomes. Effective care coordination by specialists in mental health care—managed behavioral health organizations—that have a good track record and experience with mental health, is essential.

Cost-effective options to support people with the most serious psychiatric disabilities to live productively in their communities could include a combination of regional managed behavioral health care networks for complex care management; mental health medical homes offering integrated, accountable care; cost-effective and proven peer services that offer trusting, active, supportive relationships and help to prevent relapse and avoidable emergency or inpatient care; and assertive engagement of high-cost, high need individuals who have dropped out of care.



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Additionally, OMH is working actively with the SAGE Commission and the Mandate Relief Team to identify recommendations that will lead to greater efficiencies in the operation of State government and mandate relief to localities.



Chapter 4

2010 Legislative Summary

This report contains brief descriptions of bills affecting the New York State Office of Mental Health (OMH) that passed the Legislature in the 2010 Legislative Session and whether they were signed into law or vetoed.

The summaries are based on the latest available information from the Legislative Retrieval System (LRS) operated by the Legislative Bill Drafting Commission. The status of legislation, copies of bills, veto messages, chapter laws, and other related information are available free to the public on the [LRS web site](#). 

These summaries should not be used or relied upon without actual review of the underlying statute or without consultation with Counsel. If you have any questions, please contact [David Wollner](#), OMH Counsel's Office, via e-mail or at (518) 474-1331.

Children's Services

Attention-Deficit/Hyperactivity Disorder Study VETOED Veto # 6752 **A.5602**

This legislation would have directed the State Department of Health (DOH) to conduct research as to the effects of psycho-stimulants, selective serotonin reuptake inhibitors, antidepressants and other drugs which are prescribed for attention-deficit/hyperactivity disorder (ADD/ADHD) for school-age children. The bill proposed requiring DOH to conduct this study in conjunction with OMH, the Office of People with Developmental Disabilities (OPWDD) and the State Education Department (SED) and to issue a report within two years of enactment.

Governor Paterson's Veto Message stated that the type of research and study that would be required under the bill is not within the realm of the core responsibilities of these State agencies and should be left to the physicians and researchers who treat, diagnose, and study these disorders, and further, a number of federal agencies have conducted and continue to conduct research on ADD/ADHD. The Veto Message also stated that complying with the bill would require the dedication of significant resources and, with no funding included in the 2010–11 Budget, the agencies would be forced to divert scarce resources away from other critical activities.



Community Services

Extension of Kendra’s Law A.10970

APPROVED

Chapter 139

Effective June 29, 2010 (sunset June 30, 2015)

This legislation, which was introduced at the request of the OMH, extends the sunset date of Chapter 408 of the Laws of 1999 (Kendra’s Law) from June 30, 2010, until June 30, 2015. Kendra’s Law creates a statutory framework for court-ordered Assisted Outpatient Treatment (AOT), establishing procedures for obtaining court orders for individuals with mental illness who meet particular criteria to receive and accept outpatient treatment. It ensures that people with mental illness who have a history of not complying with treatment will participate in community-based services appropriate to their needs.

Kendra’s Law was originally set to expire on June 30, 2005, was extended until June 30, 2010. However, the 2005 reauthorization of AOT required an independent evaluation of its implementation and effectiveness, specifically addressing several areas of investigation. Conduct of the study was contracted by OMH to the Department of Psychiatry and Behavioral Sciences at Duke University Medical Center, the MacArthur Foundation, and Policy Research Associates, Inc.

In June 2009, the independent study was released and concluded that the State AOT program improves a range of important outcomes for its recipients, apparently without negative consequences to recipients. The evaluation also concluded that the increased services available under AOT clearly improve recipient outcomes. Furthermore, the AOT court order itself and its attendant monitoring appear to offer additional benefits in improving outcomes. It was also determined that the AOT order exerts a critical effect on service providers, stimulating their efforts to prioritize care for AOT recipients.

Three-Year Extension of the Reinvestment Act S.8169

APPROVED

Chapter 111 (Part C)

Effective April 1, 2010

The 2010–11 Enacted State Budget includes a provision to extend the Community Mental Health Support and Workforce Reinvestment Program (Reinvestment Program) for three years, from March 31, 2010, until March 31, 2013. The Reinvestment Program requires that the majority of savings achieved from the downsizing or closure of psychiatric centers to be used for community mental health services.

Reinvestment Act Extension S.6682 and S.6683

VETOED

Veto # 6729 and 6728

These two bills passed by the Legislature, which would have extended the Reinvestment Program for seven years, were vetoed by Governor Paterson.



State Operations and Facilities

Representative Payee S.8169

APPROVED

Chapter 111 (Part A)

Effective June 14, 2010; expires June 30, 2014

This legislation was included in the 2010–11 Enacted State Budget and amends Mental Hygiene Law (MHL) to clarify that State-operated facility directors may use funds received in their capacity as representative payees to pay for the cost of care and treatment for patients.

Specifically, MHL sections 29.23 and 33.07 were amended as follows:

§29.23

- Increases from \$5,000 to \$25,000 the amount of patient funds and property (other than jewelry) that directors of department facilities may be authorized by the Commissioner to receive
- Explicitly authorizes facility directors to seek to place funds in excess of those needed to establish or maintain eligibility for government benefits into a Medicaid exception trust and requires them to do so for windfall payments (e.g., one-time payments such as a gift or inheritance) which, in combination with a person's other funds, would make the person ineligible for government benefits
- Provides for the treatment team of a person receiving services to meet with and determine the current and future personal needs
- Explicitly states that §29.23 of MHL is not applicable to federal or State benefits received by the facility director as representative payee, which benefits are to be handled per section 33.07 of MHL

33.07(e)

- Requires a mental hygiene facility director who is a representative payee pursuant to designation by the Social Security Administration or other federal agency to maintain the funds in a fiduciary capacity to the individual, but explicitly provides that the application of the funds to the cost of care and treatment of such person is not, "in and of itself," a violation of the fiduciary obligation [NOTE: not limited to department facilities]
- Requires the commissioners of mental health, developmental disabilities and alcoholism and substance abuse services to promulgate regulations regarding the management and protection of such funds "in collaboration with" persons receiving services, advocacy groups for such persons and families of such persons and Mental Hygiene Legal Services (MHLS)
- Requires the new regulations to include, at a minimum, provision regarding the use of Medicaid exception trusts, notice to "qualified persons" (as defined in MHL §33.16) of the facility's intent to seek representative payee status for a recipient of service and the establishment and maintenance of a discharge account for future needs
- Requires department facility directors to seek to place a "lump sum retroactive payment of a federal or state benefit" received as representative payee into a Medicaid exception trust if the lump sum payment, in combination with a person's other funds, would make the person ineligible for government benefits



- Provides for treatment team to meet with and determine the current and future personal needs of the person receiving services

§33.07(f)

- Requires the commissioners of OMH, OPWDD and Office of Alcoholism and Substance Abuse Services (OASAS) to post standards, regulations and/or policies established pursuant to this section in a prominent location on the agency’s website

§33.07(g)

- Requires that, upon request by a person receiving services or a legally authorized representative, the director of a department facility make available for review, on a quarterly basis, a statement of the person’s personal account

§33.07(h)

- Requires OMH, OPWDD and MHLS to collaboratively review the management of funds that have been received by a department facility director who serves as representative payee or pursuant to 29.23

§33.07(i)

- Requires OMH and OPWDD to submit and publish on their respective websites an annual report to the legislature detailing how persons’ federal benefits are being used

Abuse Hotline

APPROVED

Chapter 192

A.9825-A

Effective January 11, 2011

This legislation adds a new §33.06 to MHL to require OMH and OPWDD to establish procedures or mechanisms to receive allegations of abuse or mistreatment of individuals served by agencies and providers licensed or operated by such agencies. This requirement includes the establishment of a toll-free hotline to accept complaints. (OMH has had such a hotline for several years.)

In 2009, both houses of the legislature unanimously approved legislation (A.8972-A/S.5930-A), creating a toll free hotline to report the abuse or mistreatment of adults with developmental and or mental disabilities who are served by State-licensed and State-operated residential care facilities. Citing fiscal concerns and duplication of some existing hotlines, Governor Paterson vetoed that bill.

During the 2010 Session, the Governor’s Office and the respective State agencies entered into negotiations with the sponsors of the legislation to address the Governor’s concerns. Assembly bill 9825-A reflects the agreement that was reached between the Executive and the Legislature. The approved legislation largely codifies the existing practices and policies of the OMH (as well as OPWDD and the Commission on Quality of Care and Advocacy for Persons with Disabilities) as it relates to receiving and handling allegations of abuse or mistreatment of individuals served by agencies or providers licensed by the OMH.



Vending Operations in State Facilities

APPROVED

Chapter 532

A.6420

Effective: October 1, 2010

This legislation authorizes an expansion of the statutory preference for the establishment of retail operations in State facilities for persons who are blind or visually disabled, to include for the first time, State buildings and facilities that employ 400 or fewer State employees at a site, as well as facilities operated by the State University of New York, the Department of Correctional Services and the State Thruway Authority.

Several OMH facilities have developed vocational programs within those facilities that include food operations and convenience items. There are also several used clothing outlets within the facilities that are operated in this manner. These programs are typically part of an overall rehabilitation program aimed at increasing employment skills by providing practice and exposure to individuals to assist them to move toward competitive employment. This new law would not adversely impact these OMH programs.

Sale of Property of the Middletown Community Campus

VETOED

Veto # 6736

S.8148

This legislation proposed amending Chapter 196 of the Laws of 2008, which authorized the Office of General Services (OGS) to sell and convey a building on the property of the Middletown Community Campus (formerly the Middletown Psychiatric Center) to Orange County for fair market value. This bill would have authorized OGS to sell and convey this property to Orange County for one dollar.

OMH supported enactment of Chapter 196—the original legislation. OMH concluded that the sale of this property would have no adverse impact on the operation of the Middletown Community Campus and the proposed use of the property was consistent with the programs and uses on the campus. OMH’s support was largely predicated on the language in the legislation that required the county to pay fair market value for the property, and because of provisions of the Community Mental Health Reinvestment Act of 1993 (Reinvestment Act), the proceeds of the sale at fair market value would have been used to pay off bond indebtedness on the property.

Governor Paterson’s Veto Message stated that by rescinding the fair market value requirement the outcome would be contrary to the principles and plain language of the Reinvestment Act, would set a negative precedent regarding future land transfers and would result in the need for additional General Fund dollars to pay off the bonds and fund OMH operations.

Sale of Land on Creedmoor Campus

VETOED (8/15/2010)

Veto # 6763

A.9924-A

This bill would have authorized the Dormitory Authority of the State of New York to sell certain real property located on the campus of Creedmoor Psychiatric Center to the Indian Cultural and Community Center, Inc. (ICCC). Under this legislation, the property would be conveyed to this organization for fair market value.

Governor Paterson’s Veto Message stated that the “proposed conveyance would limit the accessibility to and the utility of the property retained by the State, yet OMH would still be obligated to expend funds and resources to maintain and secure the building and the surrounding property.”



However, Governor Paterson indicated that “OMH is willing to work with the ICCC to determine if there is an appropriate means to address the concerns that prompted this bill.” (Subsequent discussions have occurred in an attempt to find a mutually acceptable solution.)

**Posting of State Agency Reports
S.7805**

VETOED

Veto # 6796

This legislation would have required all State agencies to post reports on their agency websites that are mandated to be submitted to the Legislature. The bill also would have required that the agencies send a notification letter of this posting, as appropriate, to individual members of the Legislature, legislative officers or relevant committee chairpersons. Lastly, the bill proposed requiring the Office for Technology to establish, administer and maintain a State agency documents website to include postings of all reports issued by State agencies, departments, public authorities, or public benefit corporations.

The Governor’s Veto message stated that the bill would have created unnecessary redundancies and was not likely to have achieved its stated goals.

(Note: Currently, OMH posts various reports on the agency website, including statistical data that have been mandated by statute. OMH also has a linkage on its site that allows an internet user to access reports and statistics that have been archived. OMH also shares copies of reports directly with the legislative leaders and respective committee chairs.)

**Action Plan to Reduce Occupational Injuries
S.7500**

VETOED

Veto # 6828

This legislation would have amended Civil Service Law by requiring each State agency referenced in an annual report on occupational injuries, illnesses and workers’ compensation, issued by the State Civil Service Commission, to submit an action plan for reducing occurrences of workplace injuries in the coming year. The legislation would have mandated that State agencies permit employee participation, through authorized employee representatives, when preparing and implementing such written action plans.

Governor Paterson’s Veto Message expressed doubt that this bill would result in reduction of injuries in the workplace or savings to the State. The Veto Message also stated that agencies are already undertaking initiatives to reduce injuries to their workforce. Lastly, the Governor concluded his Veto Message by expressing his concern with the bill by stating, “We often address problems in this State by requiring reports, plans, task forces and studies. The costs of those steps are real and immediate in terms of State resources. The potential benefit is speculative.”



State Employees

Peace Officer Registry and Training A.7957

APPROVED

Chapter 491

Effective January 1, 2011

This legislation, introduced at the request of the Division of Criminal Justice Services, amends various laws to consolidate the police officer and peace officer registries and increase training requirements for peace officers. Specifically, this legislation requires each peace officer to complete a training course, consisting of no more than 180 hours, prescribed by the Municipal Police Training Council. The new training requirements would apply only to peace officers appointed on or after the effective date of the legislation. Peace officers appointed prior to January 1, 2011, would continue to be subject to the training requirements in place at the time of their appointment.

Vacation Buy-Back for Security Hospital Treatment Assistants

VETOED

Veto # 6726

S.5633-A

This bill would have authorized certain uniformed employees, including security hospital treatment assistants (SHTAs) employed by OMH, to defer up to five vacation days per year and accept monetary payment in lieu of those vacation days, payable when an employee separates from service at the employee's retirement pay rate.

Governor Paterson's Veto Message stated that the bill would increase costs for the State when eligible employees cash out their deferred vacation days. Veto Message # 6726 asserted that these types of incentives and benefits should not be enacted through legislation, but rather should be part of the State's collective bargaining process, whereby each bargaining unit and the State negotiate a contract that contains a complete package of employee benefits and accompanying salary ranges.

Miscellaneous

Family Health Care Decisions Act A.7729-D

APPROVED

Chapter 8

Effective June 1, 2010

This legislation repeals and amends various sections of Public Health Law to create the Family Health Care Decisions Act (FHCDA). This legislation establishes procedures, standards and safeguards to address the many important and difficult issues to permit family members and other surrogates to make health care and treatment decisions for incapacitated persons who are treated in general hospitals and nursing homes. Furthermore, this legislation requires the "Task Force on the Life and the Law" to form a special advisory committee to make recommendations for future statutory or regulatory changes to determine whether the Act should apply in facilities other than general hospitals and nursing homes, including mental hygiene facilities, including addressing the issues of withdrawal or withholding life-sustaining treatment for persons with mental illness or developmental disability, including those who reside in mental hygiene facilities.

In establishing the FHCDA, this legislation addressed one of the last major gaps in existing statutory law regarding surrogate decision-making rules on behalf of incapacitated patients. New York



statutory law previously did not explicitly recognize the authority of family members (or others close to an individual) to consent to treatment for adults who lack the ability to consent to health care, yet health care providers routinely turned to family members for such consent. This legislation for the first time provides clear and uniform rules by which family and other surrogates may consent to health care and treatment. The new law establishes a list of surrogates to make health care decisions if the patient lacks capacity and a health care proxy was not signed. The law also describes the procedures that must be followed by general hospitals and nursing homes to ensure that surrogates can successfully authorize treatment for persons who lose capacity.

Under this legislation, the surrogate decision-making principles would be the same for people with mental illness who are being treated in general hospitals and nursing homes, as all other patients, except that (1) a psychiatrist would have to confirm incapacity of a person with mental illness, and (2) for patients transferred from facilities licensed or operated by OMH, existing law and OMH regulations would continue to govern surrogate decisions.

This law also provides specific rules for the withholding or withdrawal of life-sustaining treatment based upon decisions by authorized surrogates. However, standards for decisions about the withdrawal or withholding of life-sustaining treatment from patients with mental illness or developmental disabilities and for patients residing in mental health facilities are not directly addressed.

A special advisory committee will be established to support the Task Force on the Life and Law to determine whether the FHCDA should apply in facilities other than general hospitals and nursing homes, including mental hygiene facilities, as well as to make recommendations regarding possible future amendments to address the issues of withdrawal or withholding life-sustaining treatment for persons with mental illness or developmental disability, including those who reside in mental hygiene facilities.

**Endangerment by a Caregiver
A.9534**

APPROVED

Chapter 14

Effective May 22, 2010

This legislation is intended to enhance criminal penalties when a “caregiver” endangers the welfare of an “incompetent or physically disabled person.” Under the new law caregivers who endanger the welfare of people who are incompetent or physically disabled could be found guilty of a class D or E felony. Previously, endangering the welfare of a person who is incompetent or physically disabled was a Class A misdemeanor.

**Public Health and Health Planning Council
S.6608-B**

APPROVED

Chapter 58

Effective December 1, 2010

This chapter merges two advisory bodies housed in DOH—the Public Health Council and the State Hospital Review and Planning Council—into a new Public Health and Health Planning Council. The new council consists of the Commissioner of Health and 24 members, and includes at least two members who are also members of OMH’s advisory body, the Mental Health Services Council.



Under the new law, the Chairperson of the MHSC is required to recommend two members of the Mental Health Services Council for appointment by the Governor to the Public Health and Health Planning Council. The new council will continue to retain the powers and responsibilities that had been previously provided to the two councils, including matters relating to improving and preserving public health and reviewing the establishment and construction of health care facilities.

Extension of Social Worker Exemption

APPROVED

S.5921-A

Chapter 130

A.11440

Chapter 132

Effective June 18, 2010

S.5921-A and its companion “chapter amendment,” A.11440, relate to Title VIII of Education Law, which pertain to the practices of the professions of social work, psychology and the four professions that are called “mental health practitioners” (i.e., mental health counseling, marriage and family therapy, creative arts therapy, and psychoanalysis).

This new law extends until July 1, 2013, the professional exemption for programs under the jurisdiction of OMH, OPWDD, and OASAS; local governmental units; and the Office of Children and Family Services and local social services districts. Extending this professional exemption means that persons who provide direct care in such programs can legally continue to provide services even though they may fall within the restricted scope of practice of one of the licensed professionals listed above. The law also expands the exemption beyond mental hygiene agencies and local governmental units to include all entities operated, regulated, funded or approved by DOH, Department of Correctional Services and State Office for the Aging.

These new laws include provisions requiring the affected State agencies work with the State Education Department on a workforce analysis of functions provided and to convene a task force to develop recommendations on further changes to statute, rule and regulation before the sunset date of the exemption.

Minority and Women Business Enterprises/ Recycled Commodities and Technology

APPROVED

Chapter 173

S.8312

Effective October 13, 2010

This law raises from \$100,000 to \$200,000 the limit for purchasing from small businesses and minority-owned and women-owned business enterprises (MWBES) or commodities or technology that is recycled or remanufactured, without formal competitive bidding. The law also requires the State Procurement Council to make recommendations to OGS for legislative or regulatory changes that will increase access to the State procurement process by MWBES, and to create model language to be used by agencies when issuing requests for bids or proposals that will increase the ability of small businesses to participate in State procurements.



Office of Mental Retardation and Developmental Disabilities Name Change to OPWDD

A.11197

APPROVED

Chapter 198

APPROVED

Chapter 168

Effective July 13, 2010

This chapter changes the name of the Office of Mental Retardation and Developmental Disabilities to OPWDD.

HIV Testing

APPROVED

Chapter 308

S.8227

Effective September 1, 2010

Chapter 308 of the Laws of 2010 authorizes significant changes in HIV testing in New York State. This new law generally requires the following:

- HIV testing must be offered to all persons between the ages of 13 and 64 receiving hospital or primary care services with limited exceptions noted in the law. (It has been determined that OMH psychiatric centers, to the extent they offer “primary care,” should comply with this requirement.)
- Prior to being asked to consent to HIV testing, patients must be provided the “seven points of information” about HIV required by Public Health Law. (However, the law’s consent provisions do not apply to tests performed in a facility operated under Correction Law.)
- The ability to consent to an HIV test is based on capacity, without regard to age. Providers offering HIV testing must make a determination as to a patient’s capacity to consent. If a practitioner determines a person under 18 years old does not have the capacity to consent, the offer of testing for the young person should be made to a parent or other person authorized to provide consent.
- Health care and other HIV test providers authorizing HIV testing must arrange an appointment for medical care for persons confirmed positive.
- Health care providers do not need to certify that informed consent has been obtained before ordering HIV testing by a laboratory or other facility. Confidential HIV information may be released without a written statement prohibiting re-disclosure when routine disclosures are made to treating providers or to health insurers to obtain payment.
- People who are comatose or otherwise incapable of providing consent may now be tested for HIV in certain circumstances without consent, if they are the source of an occupational exposure.
- The legislation requires DOH to develop model forms for obtaining written consent; providers may, however, develop their own forms based on these models.

Assaults on Nurses

APPROVED

Chapter 318

A.3103-A

Effective November 1, 2010

This law increases the criminal penalties for persons who assault nurses. Persons committing assaults on nurses, including both registered nurses and licensed practical nurses, can now be charged with a more serious Class D felony charge if physical injury is caused to these individuals.



**Mandatory Registry for the Disabled
A.520**

VETOED

Veto # 6739

This legislation would have required counties to maintain a registry of people of all ages with disabilities as a safety measure in the event of a natural or manmade disaster. Currently, a county having a local disaster preparedness plan is not required to maintain a registry of county residents with disabilities. Under the vetoed bill, counties would have been required to submit information on people with disabilities, upon permission of each person who is disabled, to State and federal agencies for their use in delivering services.

**Expanding the Authority of the State Division of Human Rights
A.8012**

VETOED

Veto # 6756

This legislation would have amended Correction Law to give the State Division of Human Rights (SDHR) jurisdiction over cases in which individuals allege that they have been discriminated against by a public agency because of a prior criminal conviction. Currently, such an individual must seek redress by commencing a CPLR Article 78 proceeding against the agency.

Veto Message # 6756 raised concerns that State agencies subject to human rights challenges would also face increased costs. The Governor’s Veto Message also expressed reservations, noting that State agencies do not have the resources to handle these new cases and many would be forced to hire outside counsel to defend them. Finally, the Governor expressed concern that the bill would also create new costs for the State in the form of compensatory damage awards, civil fines and penalties that could be awarded by SDHR.

Interagency Council for Service-Disabled Veterans

A.8296-A

VETOED

Veto # 6757

This bill would have amended the Executive Law to create the New York State Interagency Coordinating Council for Service-Disabled Veterans. Under, the bill, the Council would have included 10 agency heads or their designees including the director of the State Division of Veterans Affairs (DVA), Division of Military and Naval Affairs, OMH, OASAS, and DOH. In addition to the agency representatives, the bill would have required that the Council include nine veteran representatives with service disabilities appointed by the Governor and the State Legislature.

The Veto Message stated that although the legislation is well intentioned, many of these issues are matters addressed by the federal government and the bill may require the State to replicate services provided by the federal government. Additionally, DVA, as well as existing State Councils, are charged already with addressing veterans issues, including veterans disabled in the course of serving their country.

Veterans Mental Health and Chemical Dependency Act

A.11098

VETOED

Veto # 6786

This bill would have amended Executive Law to require the New York State Veterans Affairs Commission to develop and update—in consultation with OMH, OASAS, DOH, and State Department of Labor—a State interagency plan to improve outreach, assessment, and care for veterans and their families who are experiencing mental health and/or substance abuse problems. The Commission is primarily responsible to provide assistance to the director of the State DVA in the



formulation of policies affecting veterans and their families. The Commission also assists in the coordination of all operations of State agencies relating to veterans affairs.

The legislation would have required the Commission to develop a plan that addresses a range of issues, including, but not limited to, the need for housing that is accessible to veterans with physical and/or mental disabilities; suicide prevention; services that address the special needs of female service members or veterans; peer outreach and support programs; services to meet the emotional needs of children, spouse, and/or domestic partners of service members or veterans; services and consultation for veterans in search of employment; and accessibility and coordination of information.

The Governor’s Veto Message stated that DVA “routinely collaborates with other agencies that address matters affecting veterans,” including OMH and OASAS, regarding activities that seek to provide veterans with services or information about resources available to address mental health and substance abuse issues. The Veto Message also recognized and highlighted other interagency initiatives involving issues that affect veterans, including the Mental Health Services Council, which includes one member recommended by the director of the DVA and one member recommended by the Adjutant General of the Division of Military and Naval Affairs.

**Witnesses to a Health Care Proxy
S.1990**

VETOED

Veto # 6788

Senate Bill 1990 would have amended Public Health law so that only one witness would be needed for the execution of a proxy, except when individuals reside in mental hygiene facilities operated or licensed by OMH or OPWDD, where two witnesses would continue to be required.

The Veto Message raised concerns that the elimination of the second witness requirement would “make it more likely that a person with nefarious motives could forge another’s name and be the sole witness to the forged document.” The Veto Message noted that “while this would not be a frequent occurrence, the consequences of such action could be very serious, because the health care agent would have the authority to make all health care decisions on behalf of a patient, including decisions that could result in death.”

Providing Legal Services to Residents of Nursing Homes

A.10824-B

VETOED

Veto # 6811

A.10824-B would have amended section 47.01 of MHL to authorize Mental Hygiene Legal Services (MHLS) to provide legal assistance to patients or residents of residential healthcare facilities, including nursing homes who have been admitted directly from a psychiatric facility or a psychiatric ward of a hospital and who have a serious mental illness for which they are receiving services.

In his Veto Message, Governor Paterson stated that although “enhancing the availability of legal representation to people in nursing homes is laudable, but the bill would impose significant additional responsibilities on MHLS whose costs are ultimately borne by the State.” The Veto Message also raised a concern that the bill contains a “troubling ambiguity as to the meaning of a “residential health care facility.” The Governor pointed out that the bill’s reference to “residential health care facilities, including nursing homes” infers that something broader was intended, and “it could be argued that the definition encompasses a broader array of residential programs” which could have the potential to increase costs to the State.



**Autism Coverage
S.7000-B**

VETOED

Veto # 6832

This bill would have required State-regulated health insurers to provide coverage for treatment and therapy options for autism spectrum disorder (ASD), in accordance with regulations promulgated by DOH, in consultation with the State Insurance Department, OPWDD and OMH. Under the bill, treatment and therapy options for which coverage would have been mandated required them to be "evidence-based, peer-reviewed and clinically proven." Under the legislation, the regulations would have to have been promulgated within 12 months of the bill's enactment and would have required updates on a regular basis; the coverage mandate would have taken effect once the regulations were promulgated and would have applied to policies issued or renewed after that date.

Governor Paterson acknowledged in his Veto Message that he was "extremely sympathetic to the very real struggles faced by the families of individuals with ASD. It will be a subject of my continued advocacy as a private citizen." However, he stated that he could not sign a bill that would impose costs that the Legislature does not fund.

Notes

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