NYS ASSEMBLY STANDING COMMITTEE ON ALCOHOLISM AND DRUG ABUSE
NYS ASSEMBLY STANDING COMMITTEE ON MENTAL HEALTH
PUBLIC HEARING

Integrating Services Offered by the Office of Addiction Services and Supports and the Office of Mental Health.

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Good morning, and thank you for the opportunity to provide testimony today. To highlight how important integration is for mental health and substance use disorders advocates, our three organizations are speaking with one voice today.

The Coalition for Behavioral Health represents over 100 community-based behavioral health providers, who provide the full array of outpatient mental health and substance use services to over 600,000 New Yorkers annually. We train thousands of mental health professionals annually, and provide technical assistance to dozens of agencies each year.

The NYS Council for Community Behavioral Healthcare is a statewide membership association that represents 105 mental health and substance use disorder providers of prevention, treatment, recovery, and physical health services. Our members include freestanding nonprofit organizations as well as general hospitals, counties and a growing number of FQHCs.

The New York Association of Alcoholism and Substance Abuse Providers (ASAP) represents more than 150 organizations that provide prevention, treatment, recovery, and harm reduction services across New York State. Our membership includes a variety of multi-service health, human, and social service organizations; stand-alone addiction service providers; and both not-for-profit and for-profit organizations.

Collectively, our organizations represent the vast majority of mental health and substance use service providers in New York State. Our members serve hundreds of thousands of New Yorkers each day. It is clear to us that New York's current service delivery system is not optimally designed to meet the needs of the individuals served by our member agencies. With inadequate funding and a regulatory quagmire, substance use and mental health service providers struggle to address the increasingly complex needs of people seeking services.

The co-occurrence of mental health and substance use disorders is widely documented and common. Roughly half of all people with severe mental health disorders also have a substance abuse problem. In New York State alone, an estimated 1.4 million people - 7 percent of the state's population - suffer from co-occurring mental health and substance use disorders.[i]

It is critical that service providers and the governmental entities that fund and regulate them do everything possible to ensure that people who need help are our first priority. Working together, along with people needing services and their families, we must create a system of accessible, efficient and effective services that result in positive outcomes for those who depend on us. Our current system, however, is not optimally designed for people who have multiple and complex needs. Increasingly, we hear about the experiences of people who have been turned away when they seek care because New York's system still has bifurcated paths to access care for substance use and mental health disorders. People are not well-served when they go to a local provider who is

barred from serving them and has to send them outside their community to an unfamiliar organization because they had the wrong primary diagnosis. Some people, especially children with both mental health and substance use challenges, are shuffled between agencies with no one responsible for the wholistic care of the child/family. This is not what our system should look like.

Federal and state parity laws require New York to treat mental health and substance use disorders on par with the way physical health disorders are treated. However, we have yet to address all of the barriers that prevent people from accessing behavioral health services at parity with their physical healthcare. We must address all health inequities and end fragmentation in New York's system of care. New Yorkers deserve better.

The failure to prioritize individualized and integrated care often makes the critical work of behavioral health providers far more challenging than is necessary. Staff, who entered this field to help people, find their days filled with paperwork. Even with the work done by program leadership and staff to create more efficient processes and whole-person centered care, programs continue to be stymied by regulatory barriers and high costs associated with integration.

New York State took action over the last several years to increase the integration of mental health and substance use care. Both the Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) require that people seeking help are assessed at intake for both mental health and substance use disorders (SUD). If a person at an OMH-licensed treatment program has a primary diagnosis of mental illness and a secondary diagnosis of SUD, the program can treat both disorders or, if clinically necessary, refer the individual to an OASAS-certified addiction treatment program to address the SUD. For OASAS-certified treatment programs, the same process holds true.

The need to integrate treatment was a center-piece in New York's 2015 DSRIP Plan and was a required component of the service design expected of all grantees chosen to participate in that initiative. During the five-year DSRIP period, hospital and community providers could obtain waivers of NYS' regulations and were able to offer integrated care through a streamlined application process. If the applicant was a licensed/certified OMH and OASAS treatment provider (even if the programs were not at the same location), any or all of their OMH and OASAS program sites could apply to become integrated OMH/OASAS treatment programs. Unfortunately, the vast majority of DSRIP funding went to hospitals and health systems for other purposes, leaving so-called 'downstream' community providers without the resources and supports to accomplish greater integrated care. In all DSRIP projects that did invest in integration of substance use, mental health and physical healthcare integration, significant cost savings were realized and health outcomes were dramatically better.

The service providers that comprise the membership of our three organizations are very concerned that significant barriers to providing integrated care still remain. Examples of this are:

- When a person receiving treatment in an OASAS-certified program completes treatment for their substance use disorder, but still has mental health concerns that need to be addressed, they must be discharged and referred to a mental health treatment program. The same is true in reverse for a client of an OMH-licensed mental health program. This requirement disrupts effective treatment relationships and impedes recovery. Many of the individuals referred to other programs to complete their treatment do not make it to their first appointment.
- If a person's primary diagnosis is not aligned with the program's certification (a mental illness for an OMH program or a substance use disorder for an OASAS program), they must be referred to the "right" program even when they have a secondary disorder that is aligned with the program's main certification.

Whether a New Yorker seeks help at an OMH or an OASAS certified treatment program, the goal of the State must be that help is available whatever door they walk through. New Yorkers should be able to remain engaged with the behavioral health treatment providers they know, trust and seek help from when they have co-occurring disorders. Many OMH and OASAS certified programs already offer treatment for both disorders. The ease of access to a full continuum of substance use and mental health disorders services must be more widespread and available in all New York communities.

New York State must take action to streamline the regulatory process for certifying integrated treatment of mental health and substance use disorders. The following recommendations provide a clear pathway to accomplish this:

1. An agency that is certified by and in good standing with both OMH **and** OASAS to offer outpatient treatment (even if the respective programs operate in different locations) should be able to integrate any and all outpatient treatment programs certified by OMH and/or OASAS using a simple integrated licensing application that suffices for both NYS agencies and the local government unit (LGU). Such an application could request integration of multiple sites using one easy to complete application; in sharp contrast to the duplicative, overly complicated process currently in place. The State and the local government unit (LGU) should be required to establish a process for review and approval of completed applications within a set timeframe, preferably 60 days or less.
2. Community-based service providers certified by, and in good standing with, either OMH **or** OASAS should be permitted to submit a streamlined certification application to the other NYS agency, with a requirement that a decision on the application be made within 90 days.
3. A simple integrated licensing application to both NYS agencies and the local government unit (LGU) to integrate multiple sites should be permitted. NYS and the

LGU should be required to establish a process for review and approval of completed applications within a set timeframe; preferably of 60 days or less.

4. For integrated treatment programs, the original certifying agency--either OMH or OASAS--should take the lead in the future for oversight, audits and certification renewals. Both agencies should collaborate on these activities and be required to develop processes that are non-duplicative with integrated program guidance and audit standards.

Integration should also be extended to supportive housing, recovery and prevention services. Whether or not NYS combines OMH and OASAS into one agency, rigid guidelines and regulations that impede integration of mental health and substance use services have to end, especially to better address the co-occurring disorders that close to 50% of people seeking services experience. For those who do not have co-occurring disorders, the service system should be able to offer the specific specialty care needed.

New Yorkers who need services and the community agencies who provide services are in alignment in relative to advocacy for a complete continuum of services that addresses the individualized needs of the whole person. Particularly, given the pandemic-related financial stress on community agencies and the escalating demand for behavioral health services post-pandemic, NYS must transform its services system to one that is streamlined and integrated and where duplicative and complicated paperwork is eliminated.

In closing, we ask that the dedicated workforce that provides mental health and substance use disorders services receive the compensation they deserve. In order for any of our recommendations to have meaning, we must have a commitment in the NYS budget that allows community-based programs to recruit, train, and retain a strong workforce. It is also imperative that programs receive funding support and rates that are adequate to pay for the cost of delivering services. Programs must be given the resources to compensate their staff and to cover the cost of doing business, or we will lose staff, see more agencies closing their doors, and have dual epidemics of addiction/overdose and mental health/suicide continue to escalate.

Thank you for holding a hearing on this critical topic. We look forward to partnering with you to rethink the current siloed approach to NYS oversight, certification and funding of mental health and addiction services.

[i] Isaacs S, Jellinek P, et al. New York State Health Foundation: HEALTH AFFAIRSVOL. 32, NO. 10: ECONOMIC TRENDS & QUALITY TRADE-OFFS
New York State Health Foundation: Integrating Mental Health and Substance Abuse Care
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