

**Mental Health Association
in New York State, Inc.**



2005

**Legislative
Briefing Book**

Mental Health Association in New York State, Inc.

194 WASHINGTON AVENUE, ALBANY, NY 12210, SUITE 415
Working to ensure available and accessible mental health services for all New Yorkers



Glenn Liebman, *CEO*

Mark Gustin, *Chair of the Board*

March 7, 2005

Dear Governor Pataki and Members of the NYS Legislature:

On behalf of the Mental Health Association in New York State, Inc. (MHANYS), I am pleased to provide you with our *2005 Legislative Briefing Book*.

The process by which we formulate our legislative agenda begins with a unique public hearing process conducted during MHANYS' annual meeting every fall. Testimony is received from any and all interested parties, both within the Mental Health Association community and others who have overlapping interests with our own. This testimony is reviewed by the MHANYS' Government Affairs Committee, under the direction of Committee Chair Sylvia Lask, and is used to create our advocacy agenda. The agenda then forms the basis of MHANYS' *Legislative Briefing Book*, which fully details the agenda items.

This year, MHANYS' Legislative Agenda includes:

- Timothy's Law
- Increased housing availability and capacity
- Planning for the future that includes input from all stakeholders
- Continued access to medicaid, including open access to prescription drugs
- Prison and jail reform, including elimination of SHU for inmates with mental illness

As 2005 unfolds, we hope that these materials will assist you in determining your position on the major issues facing individuals with mental illness throughout New York.

Thank you for giving us the opportunity to provide our input. On behalf of the our statewide network of local Mental Health Association affiliates serving 55 counties across our state, MHANYS appreciates the generous time and consideration you give to these most pressing issues.

As always, if you have any questions, or if we may assist you in any way, please do not hesitate to contact us.

Very truly yours,

Glenn Liebman



Mental Health Association in New York State, Inc.

2005 Legislative Agenda

- Timothy's Law** End health insurance discrimination by enacting parity in coverage for mental health and addiction services as is provided for other health services
- Housing** Increase availability of housing for individuals with mental illness. Additional capacity in community residences (CR), single room occupancy (SRO) and supported housing are necessary to provide housing, especially for targeted populations such as homeless individuals, those leaving jails and prisons, and adult home residents.
- Planning** Establish a plan for the future provision of services in the mental health health system. All stakeholders in the mental health system, especially those at the local level, must be involved in discussions and implementation of any changes to the existing mental health system. Such planning is not limited to, but must address issues concerning:
- the availability of housing
 - the closure of psychiatric centers
 - development of services for aging population
 - continued development of services for children
 - qualified workforce to deliver safe and effective treatment
- Access to Medicaid** Ensure that individuals living with mental illness have access to the services and treatment currently provided under Medicaid, including open access to prescription drugs.
- Prison and Jail Reform** Prevent children and adults with mental illness from becoming involved, or further involved, with the juvenile justice system and adult criminal justice system through diversion programs, eliminating inappropriate treatment, and ensuring appropriate post-release support.
- Ensure all eligible individuals leaving the correctional system have Medicaid coverage
 - Eliminate solitary confinement for inmates with mental illnesses



2005 Legislative Briefing Book

TIMOTHY'S LAW

Mental Health and Chemical Dependency Insurance Parity

- Briefing Paper – *Timothy's Law* for Mental Health and Chemical Dependency Treatment
- Timothy's Story
- Supporters of *Timothy's Law*
- Open Letter to Small Business Owners from Susan Wheeler, Chair of *Small Businesses For Timothy's Law*



2005 Legislative Briefing Book



Timothy O'Clair

May 5, 1988 - March 16, 2001

Timothy's Law for Mental Health and Chemical Dependency Parity

In March of 2001, twelve year-old Timothy O'Clair hanged himself in his bedroom closet. Timothy and his family spent nearly five years seeking the necessary treatment and services for his emotional disorder. When Timothy's parents, Tom and Donna, sought help for their son, they quickly ran into barriers. Those barriers were the limits on coverage under insurance policies for mental health and substance abuse services. It is Tom and Donna's belief that had their health insurance policy provided equal coverage for mental health and chemical dependency services, as are provided for other health services, Timothy would be here today.

The O'Clair's experience is not unique. Every private insurance policy in New York limits the amount of inpatient and outpatient coverage provided for mental health and substance abuse services, or requires additional co-payments from the insured. Simply put, these policies discriminate in the coverage they provide based upon diagnosis of mental illness or substance abuse disorder.

In an effort to eliminate this discrimination, Timothy's Law goes beyond the *Federal Mental Health Act*, enacted in 1996 and renewed again in 2002, to completely eliminate discriminatory and unequal insurance coverage for mental health and substance abuse services by insurance companies. Timothy's Law mandates that insurance providers covering any health care services must also provide coverage for mental health and substance abuse services, and that coverage and cost must be 'on par' with all other health care services covered under such policy.

In 2002, PricewaterhouseCoopers conducted an actuarial study on similar legislation regarding the estimated cost to mandate such coverage in insurance policies. Based upon the prior experiences of thirty-four other states that have already passed some form of parity, the actuarial studies conducted on the implementation of parity in those other states, and the particular circumstances of New York, the final report estimated the cost of implementing mental health and substance abuse parity legislation at **\$1.26** per insured person per month. Had mental health and substance abuse parity been the law, it would have cost \$1.26 per month to provide Timothy with the mental health service coverage he needed, rather than charging his parents hundreds of dollars per month. More importantly, Timothy would have received the services he needed and most likely would be here today.

The lack of parity has forced thousands of other families throughout the state, including the O'Clairs, to relinquish custody of their children with mental illness, solely for the purpose of getting such children the mental health services they need. Such placement provides the child unrestricted access to mental health services through Medicaid. However, in situations like this, publicly funded social service programs must also pay for the child's housing, education, and other health care expenses, costing as much as hundreds of thousands of dollars per year for each child.

With passage of Timothy's Law, New York State could avoid much of these expenses by returning the cost of providing mental health care to the proper sources – health insurers and the intact family unit.

When contrasted with the costs associated with undiagnosed and untreated mental illness and addiction, \$1.26 per month is a very modest cost. Left untreated, these ailments can lead to or contribute to accidents, job turnover, interpersonal conflict, disability, worker's compensation, involvement with the criminal justice system, disrupted lives and families, and increased dependency on public resources. In fact, the *Journal of the American Medical Association* estimates the cost of lost worker productivity, due to depression alone, at more than \$44 billion annually, nationwide.

The enactment of Timothy's Law will end the discriminatory practice of providing unequal insurance coverage based on diagnosis, help curb the stigma associated with mental illness and substance abuse, and will allow children like Timothy to receive the services and treatment they need to live full and productive lives.



2005 Legislative Briefing Book

Timothy's Story



Seven weeks before his 13th birthday, Timothy O'Clair completed suicide. The youngest of three children in his Schenectady family, Timothy hung himself in his bedroom closet on March 16, 2001.

Born May 5th, 1988, Timothy was much like any other boy - beginning life as an active, happy energetic baby; growing in size and interests. He loved fishing, baseball, camping, bowling, and building things with his hands.

As Timothy grew, he began to exhibit some problems, beginning with attention issues. At the age of seven, he was becoming easily frustrated and developing a serious temper. By his eighth birthday, his family became convinced that he needed help. His parents, brothers and his school began to recognize problems that were growing. In the spring of 1996, the school principal shared with Timothy's family an essay written by one of Tim's brothers. Although the essay said that he wanted to hurt his mother, the family believed it was written as though it was seen through Timothy's eyes.

The family sought help, and quickly learned that access to mental health services in New York State is unequal and discriminatory. Timothy's pediatrician referred the family to a psychological group in Albany County, and a psychiatrist in Saratoga County. For four years, the family worked together, as well as separately, with the psychologists, in an effort to keep their family together.

Although the O'Clair's health insurance was through Mr. O'Clair's employment with the New York State Thruway Authority, they quickly learned of the discrimination against mental illness (and chemical dependency) in coverage. Their policies, through MVP and then CDPHP allowed only 20 outpatient visits per year for the psychiatrist and psychologist combined. While both their physical health and mental health insurance co-payments were \$10 per visit initially, mental health visits became \$35 each after just a few visits. The visits became very expensive, as the family quickly used up their coverage limits and began having to pay all of it themselves. Each year, they would experience the same spiraling cost trend.

When the O'Clairs were able to access care and services, they really believed the treatment they attained was high quality. The problem was that it was limited and sporadic, as insurance and the family budget allowed.

At the end of fourth grade, Timothy began to refuse to attend school. In 1998, Timothy had his first inpatient admission at Four Winds Hospital in Saratoga. After throwing rags into their home furnace the week before Christmas, Timothy was admitted to that psychiatric hospital for a week and a day. The insurance company stopped paying for the hospitalization, and Timothy went home.

While at Four Winds, Timothy had made an unfounded allegation of abuse by his father, which brought the family into contact with the Schenectady County Department of Social Services (DSS). The family worked with DSS for two years, at one point filing a PINS petitions against Timothy, to get him to go to school. Over the years, Timothy was diagnosed with Depression, Attention Deficit Hyperactivity Disorder, and Oppositional Defiance Disorder.

In Spring 1999, shortly after the shootings at Columbine, Timothy, now in 5th grade, pushed back a school bathroom ceiling tile and climbed in for no known reason. The family continued to pursue outpatient treatment, but because of the cost, and the need for the other members of the family, they couldn't go as often as necessary, things in the O'Clair household grew steadily worse and the family became concerned with their safety. They needed residential care for Timothy – care that simply was not available through their health insurance. With Timothy spiraling downward, the O'Clairs reached out again to DSS. Timothy was hospitalized at Ellis Hospital for a week and a half.

They felt they had no alternative but to place him in foster care. In New York State, when a child goes into foster care, he or she automatically become eligible for Medicaid, which will pay, at taxpayer expense, for all of the services insurance companies refuse to provide.

For nine months, the O'Clairs had placed Timothy in shared custody. This meant that the government would decide with whom Timothy lived. It also meant the O'Clairs would pay statutory child support to Schenectady County. For six months, the O'Clairs had \$226.00 taken out of every bi-weekly paycheck.

Timothy bounced around the system - his first month was a state-run residence in Albany. After that, he spent three days with a foster family that the O'Clairs found completely unacceptable. Then, on to a respite/foster home in Altamont. After about a month in foster care, Timothy returned home, while the O'Clairs waited for a residential placement spot in a state program to open up. After a short while, one did - at Northeast Parent Child Society. He was there from June of 2000 until January of 2001.

After significant improvement, Timothy came home from Northeast on his mother's birthday. For three weeks, he did well. Although the family continued to participate with their psychiatrist at Four Winds Hospital, and their psychologist at Karner Associates, things began going downhill again.

Timothy was becoming violent again, and it all came to a head the night he died. He refused to take his medications. He broke all the trophies he had received over the years, which he'd collected in his room. He dumped all his dresser drawers and the clothes in his closet on his bedroom floor. He told his brother he'd kill himself, as he had threatened suicide many times before. The family did not know how serious he was, as he had claimed this so many times in the past.

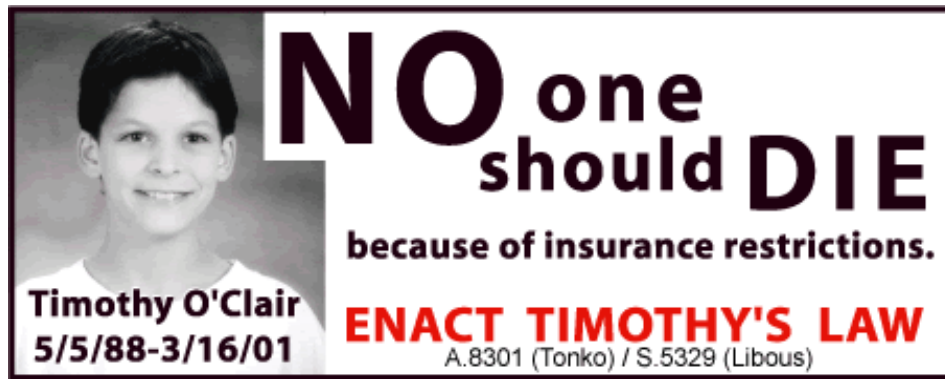
While his father was working and his mother was out with his brother, Christopher, Timothy was in his room home. John, his oldest brother who was then 16, was in his room doing his homework. When Donna returned home, she found that Timothy had hung himself in his bedroom closet. Christopher helped his mother get him down, and John called 911, but Timothy was gone.

Even after his death, the family continued to pay child support to cover his stay at Northeast, and were still paying Ellis Hospital for his 3 day extended stay not covered by insurance. The family finally went to Family Court to get the child support garnishment stopped.

The family trauma and agony continues to this day. Christopher, who is now in college, is still trying to deal with the loss of his little brother, and what he saw that night.

John, the eldest son, is a student at the College of St. Rose, studying to be an elementary school teacher and also trying to move on from that horrific night.

Together the family lives with a haunting reality. If New York had equal coverage for mental health and substance abuse services, which would cost New Yorkers only pennies a day, Timothy might have gotten the treatment he needed.



Supporters of Timothy's Law

The O'Clair Family
 Miss New York State, Jessica Lynch
 Albany Citizens Council on Alcoholism
 Alcohol and Substance Abuse Providers of NYS
 American Academy of Pain Management
 American Diabetes Association
 American Heart Association
 American Lung Association
 AMI Albany Relatives
 AMI Consumers of Schenectady
 AMI of Chautauqua
 Argentine American Medical Society
 ARISE
 Association for Community Living
 Association of Boards of Visitors
 Boro Park Parents of Young Adults with Special
 Needs
 Brooklyn Peer Advocacy Project
 Broome County NAMI/Families for Mental Health
 Center for Disability Rights
 Center for Urban Community Services
 Child and Adolescent Bipolar Foundation
 Children's Defense Fund of New York State
 Children's Mental Health Alliance
 Citizen Action of New York
 Citizen's Committee for Children
 Civil Service Employees Association of New York
 Coalition of Voluntary Mental Health Agencies
 Cortland County NAMI, Inc. REACH
 Disability Advocates
 Ellis Hospital Mental Health Services
 Family & Children's Service of the Capital Region
 Families Together in New York State
 Fireman's Association of the State of New York
 Friends & Advocates for Mental Health/NAMI
 Sullivan County
 Greater New York Hospital Association

Health Care For All Campaign
 Jamaica AMI Neighborhood Care Team
 Local 1199, SEIU
 Long Island Recovery Advocates
 Lutheran Statewide Advocacy
 Medical Society of the State of New York
 Mental Health Association in New York State
 Mental Health Association of Westchester
 Mental Health Association of Nassau
 Mental Health Association of New York City
 Mental Health Empowerment Project
 Metro New York Health Care For All Campaign
 Mothers and Babies Perinatal Network of SCNY, Inc.
 NAMI- A.M.I.C.O.
 NAMI - Champlain Valley
 NAMI April of Brooklyn
 NAMI Chautauqua County
 NAMI Chemung/Steuben Counties (NAMI-CSC-NY)
 NAMI Columbia County Relatives Support Group
 NAMI Concerned Citizens for Pilgrim Psychiatric
 Center
 NAMI East Flatbush
 NAMI Families & Friends of the Nathan S. Kline
 Institute
 NAMI Finger Lakes
 NAMI Friends of the New York State Psychiatric
 Institute
 NAMI Huntington
 NAMI in Buffalo & Erie County
 NAMI in Ulster
 NAMI Long Island Regional Council
 NAMI Mental Health Association in Jefferson County
 NAMI Niagara
 NAMI North Country
 NAMI of Cayuga County
 NAMI of Central Suffolk
 NAMI of Delaware County
 NAMI of East Brooklyn

NAMI of Eastern Long Island
NAMI of Greene County
NAMI of Montgomery, Fulton & Hamilton Counties
NAMI of Nassau County Medical Center
NAMI of Ontario, Yates & Seneca Counties
NAMI of Otsego County
NAMI of Rochester/Families & Friends of the
Mentally Ill
NAMI of Saratoga Springs
NAMI of Westchester
NAMI Personality Disorders
NAMI PROMISE
NAMI Queens/Nassau
NAMI Schenectady
NAMI Troy-Rensselaer Counties
NAMI/FAMILYA of Rockland County
NAMI-Harlem
NAMI-Mid-Hudson
NAMI-NYC Staten Island
NAMI-Southwest Nassau
National Alliance for the Mentally Ill - New York City
Metro (NAMI-NYC Metro)
National Alliance for the Mentally Ill of New York
State (NAMI-NYS)
National Association of Anorexia and Associated
Disorders (ANAD)
National Association of Social Workers - NYC
Chapter
New York Association of Psychiatric Rehabilitation
Services
New York State Academy of Family Physicians
New York State Catholic Conference
New York State Coalition Against Domestic Violence
New York State Coalition for Children's Mental
Health
New York State Council for Community Behavioral
Healthcare
New York State Council on Behavioral Healthcare
New York State Nurses Association
New York State Occupational Therapy Association
(NYSOTA)
New York State Presbyterian Hospital, Department of
Psychiatry
New York State Psychiatric Association
New York State Psychological Association
New York State Public Health Association
New York State Rehabilitation Association
New York State Society for Clinical Social Work
New York State United Teachers
North Shore NAMI
Northern Regional Center for Independent Living

NYSPTA Special Ed
Oneida NAMI-Hope
Prevent Child Abuse New York
Public Employees Federation
Putnam County NAMI
Riverhead AMI
Samaritans Suicide Prevention Center
Schuyler Center for Analysis and Advocacy (SCAA)
Self-Advocacy Association of NYS
Social Work Alliance NASW-NYS, NYC and 1199
SEIU
Southern Tier Independence Center
St. Lawrence Valley AMI
Suicide Prevention Action Network (SPAN)
Supportive Housing Network of New York State
Taconic Resources for Independence
The Network-Enstage Renal Disease
Timothy's Law Campaign
UJA Federation of New York
Workers Against Mismanagement
YMCA Chapters of NYS



Dear Fellow Business Owner:

As business owners, we are well aware of the increasingly exorbitant cost of providing health insurance to our employees. These costs can bring us dangerously close to the break-even point, and often prevent us from providing our employees with the benefits we know they need. Indeed, when new benefits are proposed, we often just want to scream in exasperation and say, "Enough, I can't afford what I am paying for as it is!"

*However, did you ever stop to think about how much more it costs you to **not** provide generous health insurance to your employees?*

Many large businesses have now determined that providing their employees high quality health insurance, with generous benefits, is actually better for their bottom line than providing health insurance with lower benefits. These businesses have learned from experience that providing employees with employees access to the services and treatment they need, when they need it, greatly reduces the costs associated with absenteeism and lost productivity.

This is just as true for mental health and addiction needs. Companies like American Airlines, AT&T, Delta Air Lines, Dow, Dupont, Eastman Kodak, Federal Express, General Motors, IBM, Pepsico, Pfizer and Xerox offer mental health benefits that far exceed the mandated minimum requirements that smaller employers like me offer. These larger businesses are trying to reduce the amount of money they lose to absenteeism, tardiness, preoccupation, distraction and dysfunction among employees with mental health needs. As a whole, mental illness costs US businesses \$79 billion annually in lost productivity.

In a recent interview with National Public Radio on the costs of depression, the former Director of Benefits Strategies at Delta Airlines, Dr. Miles Snowden, said, "For every \$1.00 that we have spent in providing behavioral health benefits, we are getting \$1.50 back in terms of reduced absence from work and improved productivity."

It's also important to note that businesses that offer generous mental health and chemical dependency insurance benefits experience lower usage rates of health care services altogether. In fact, when a large Connecticut corporation implemented a 30% cost reduction in mental health services, it triggered a 37% increase in medical care use and sick leave by employees using mental health services, thus costing the corporation more money rather than less. Indeed, former US Surgeon General David Satcher was right when he said, "There is no health without mental health."

Large employers aren't the only businesses losing money to the mental health needs of employees. When it comes to smaller employers, we are actually at higher risk of being negatively effected by mental health needs and stand to be hurt more than larger employers. NYS Assemblymember Joel Miller (R-Poughkeepsie), a dentist and small business operator for 35 years explains that, "Small businesses do not have the depth in the number of employees to be able to fill in for the worker who is being a good parent or family member. If an employee is distracted by their mental health needs or those of their family, they aren't a productive worker, and the business suffers. Small businesses really can't afford to not provide this coverage."

To get an idea of how much mental illness is costing my business, I recently used the 'Depression Calculator' available online through the MacArthur Initiative on Depression and Primary Care at Dartmouth & Duke (<http://www.depression-primarycare.org/organizations/employers/calculator/>). With seven employees, they

P.O. Box 708, Whitney Point, New York 13862
Telephone: (607) 849-4925 * Fax: (607) 849-4925 * E-mail: StarGrpInc@aol.com

estimate that depression, alone, causes my business to lose twelve work days each year to poor-at-work productivity and nine work days each year to absenteeism.

On top of the fact that small businesses like ours are losing money to mental health needs, our businesses also suffer because of the distinct competitive advantage many large employers hold over us when it comes to recruiting and retaining highly qualified employees. In addition to the often higher salaries that larger organizations are able to offer, a better health benefit package makes working for one of these larger employers that much more attractive than working for smaller businesses like ours.

So, how much would it cost us small employers to provide our employees with better mental health benefits so that we have a healthier workforce and we are able to eliminate the disadvantage we face? According to the actuarial firm, PricewaterhouseCoopers, providing more generous mental health and chemical dependency treatment benefits would cost an additional \$1.26 per person per month in health insurance premiums. This \$1.26 would ensure that mental health and chemical dependency benefits equal to the other health services covered under all insurance policies. Not only do I think that \$1.26 per month is an adequate investment in my employees and their families, but the long term benefits of a healthier workforce will help my business grow and help level the playing field with larger employers.

It may seem odd that as a small business owner, I support a health insurance mandate. But the most basic rule of insurance is to spread risk over the largest pool possible. If all insurance policies provided parity-based mental health and chemical dependency benefits, all businesses would benefit in the long-run from the increase in productivity and the reduction of absenteeism.

Therefore, as a small business owner, I am joining Assemblyman Miller and others in supporting efforts to enact what has now become known as Timothy's Law. The bill is named in memory of Timothy O'Clair, a 12 year-old Schenectady boy who took his own life nearly four years ago after his parents were unable to get him the mental health services he needed. The law currently allows insurance companies to limit the coverage they provide for mental health and chemical dependency services. Timothy's Law would require all health insurance policies to cover benefits for mental health and chemical dependency services and treatments equal to the benefits provided for other health conditions, like diabetes, cancer or others.

In the case of Timothy's father, Tom, his employer lost over 800 hours of work time as he struggled to get his son the services he needed. That number says nothing of his decreased productivity at work, as he was preoccupied with his son's condition. Not only that, but Tom and his wife were forced to grapple with relinquishing custody of Timothy to the county so that he could access services as a Medicaid recipient. This was devastating to the family and placed the burden of providing care on the individuals and businesses that pay taxes in New York.

I ask you to join me as a 'Small Business for Timothy's Law' and support efforts to enact Timothy's Law. If you would lend the name of your business to this effort, we can work together towards the creation of a better, stronger workforce that will in turn, be able to help us grow into better, stronger businesses.

For more information on joining 'Small Businesses for Timothy's Law,' go to www.timothyslaw.org.

Thank you for your consideration.

Sincerely,

Susan Wheeler
Owner



2005 Legislative Briefing Book

Housing

- **Briefing Paper - Increased Availability and Capacity of Housing for Individuals Living with Mental Health Needs**



2005 Legislative Briefing Book

Increased Availability and Capacity of Housing for Individuals Living with Mental Health Needs

CAPACITY ISSUES

According to recent estimates, there are over 32,000 residential beds in New York State for individuals with mental health needs (including those currently in the pipeline). Though MHANYS has been supportive and appreciative that the number of beds has increased in recent years and that additional funding has been proposed in the budget for supported housing rates, these positive changes by themselves are not enough to meet the increasing need for housing for people with psychiatric disabilities.

Currently, there is no housing assessment that provides the community with an estimate of the number of individuals with psychiatric disabilities who need housing. However we do know that there are an estimated 227,000 people in New York with serious and persistent mental illness. Clearly, the current number of residential beds does not come close to the overwhelming need for additional housing. MHANYS' fully supports Assemblymember Peter Rivera's bill, A.2995, which would establish a waiting list for individuals with mental health needs seeking housing. While passage of this bill into law would be a significant step in the right direction, we must also pay particular attention to specific priority populations in desperate need of housing, including:

- Individuals who are homeless and have a mental illness
- Individuals with mental health needs in adult homes who want to live more independently in the community
- Individuals with psychiatric disabilities in nursing homes
- Individuals with psychiatric disabilities released from jail and prison
- Individuals with psychiatric disabilities living at home with aging parents

HOUSING SAVES STATE TAXPAYERS MONEY

In 2000, the University of Pennsylvania did a study comparing the cost of 5000 individuals who have a mental illness and are homeless versus providing supportive housing for those individuals. According to the study, the average cost to taxpayers of someone who was homeless and had a mental illness was approximately \$40,500 annually (includes cost of living in shelter, possible incarceration and possible hospitalization). Contrast that with the average cost of independent housing and comprehensive mental health and employment services at \$16,282 annually. Clearly, this points out the savings to New York's taxpayers by providing housing for New York's most vulnerable population. Not only is it the more humane response to provide housing but it is also the most cost effective response as well.

HOUSING RECOMMENDATIONS

A) Establishment either through legislation (Assemblymember Peter Rivera's bill A.2895) of a needs assessments of the number of individuals with psychiatric disabilities who are in need of housing including the level of housing need (i.e.-SRO, Community Residence, Supported Housing, etc.).

B) Establishing a trend factor for direct care workers to increase current direct care staff salaries to be competitive with industries other than fast food and ensure a yearly cost of living adjustment, as is currently provided to direct care staff caring for individuals with mental retardation and developmental disabilities.

C) Utilize Best Practice models for housing, like many not-for-profit housing agencies in New York State, including the Home to Stay Program run by the Orange County MHA, Rehabilitation Support Services and the Orange County NAMI, currently operate. The Office of Mental Health should work with advocacy organizations to identify programs that are most innovative and would be appropriate for replication throughout the state.

D) Creation of an advisory group of advocates and housing providers to work with the Governor's Interagency Task Force on Housing to identify strategies for acquiring affordable properties for individuals with psychiatric disabilities. Innovative uses of funding from the Office of Mental Health and Division of Housing and Community Renewal and local housing providers has helped in the acquisition of property for individuals with psychiatric disabilities, such an advisory group could only help in this endeavor, including pushing for additional funding for such initiatives. An advisory group would help in development of additional innovative strategies for property acquisition. Only through additional resources, increased collaborative efforts among stake holders and government, and innovative responses to the housing needs of individuals with psychiatric disabilities will we be able to respond to the current unmet housing needs.



2005 Legislative Briefing Book

Comprehensive Plan for Community-Based Mental Health Services

- **Briefing Paper - Comprehensive Plan for Community-Based Mental Health Services**



2005 Legislative Briefing Book

Comprehensive Plan for Community-Based Mental Health Services

Decades ago, New York embarked upon a policy of ‘deinstitutionalization’ in an effort to move individuals with mental health needs from psychiatric centers into less restrictive housing and treatment environments in the community. Instead, due in part to a lack of adequate planning and funding to create the appropriate services and programs, New York has instead experienced ‘transinstitutionalization.’ An entire population of individuals living with mental illness have transitioned from psychiatric centers into other institutional settings such as jails, prisons hospitals, nursing homes and adult homes.

The most important step toward creation of a comprehensive system of mental health care that meets all the needs of New Yorkers with mental health needs is the development and implementation of a plan. Such a plan must include input from all stakeholders, including consumers, family members, providers, advocates and the workforce – for they all play a role in the process of recovery from mental illness. Such a plan must ensure that services and treatments meet the needs and desires of individuals with mental illness and ensure that such services and treatments are available and readily accessible.

Over the past several years, significant strides toward this end have been made through the NYS Assembly’s Mental Hygiene Task Force, in which MHANYS’ played a crucial role in advocating for its creation and in which MHANYS’ also participated. In addition, the NYS Office of Mental Health’s annual *Statewide Comprehensive Plan for Mental Health Services* has been vastly improved over the past couple years, using input from advocates and stakeholders as the basis for its planning.

As we move forward, development of future plans must include all involved stakeholders, in all communities throughout the state, especially as the future of New York’s state-operated inpatient psychiatric system is considered. This way, the system of mental health care will be capable of meeting the ever-changing needs of all children and adults with mental illnesses.

One mechanism that will enhance the planning process is to strengthen the role of the mental health sub-committees of the Community Services Boards. Under the initial Reinvestment Act of 1999, a planning process was created, providing for the inclusion of recipients of services and family members as participants in these sub-committees. Though Reinvestment funding has dramatically declined, the planning process remains in place but the sub-committees have lost much of their ability to effect policy changes. MHANYS’ supports a local planning process that strengthens the roles of mental health sub-committees and allows recipients and family members to become active participants at the local level for policy and funding decisions.

New York State's mental health system must:

- Ensure the availability of housing
- Address the downsizing of the state-operated inpatient psychiatric system
- Develop and implement services for the increasing number of older individuals with mental health needs
- Continue to work toward development of services that help stem mental illness in children
- Ensure a qualified workforce is available to deliver safe and effective treatment and services.



2005 Legislative Briefing Book

Protecting Access to Safe and Effective Medications and Treatments

- Briefing Paper - Protecting Access to Prescription Drugs in Medicaid
- Sign-on Letter in Opposition to Preferred Drug Program
- Briefing Paper - Electroconvulsive Therapy Patient Protections



2005 Legislative Briefing Book

Protecting Access to Prescription Drugs in Medicaid

As New York continues to look for ways in which to reduce the cost of Medicaid, the Governor has once again proposed the implementation of a Preferred Drug Program (PDP), which would only allow drugs approved by a committee to be available to Medicaid recipients. While well-intentioned, such a program would gravely impact the ability of Medicaid recipients with mental illness to get the medications their physician has prescribed.

This year's PDP proposal is very similar to proposals from past years, in that atypical anti-psychotic, anti-depressant, anti-retroviral and anti-rejection medications are all carved out. While the proposed carve-out is important and greatly appreciated, it unfortunately does not go far enough. Many of the medications for bi-polar disorder, anxiety disorders, and other debilitating mental illnesses and all of the medications prescribed to deal with the crippling side effects of many mental health drugs would still be subject to the PDP. In addition, when considering the fact that more than 50% of individuals with a serious mental illness have co-occurring serious physical illnesses as well, even with the exemptions listed in the Governor's proposal, a PDP would create a greater strain on this vulnerable population.

The proposal fails to include any consumer representation on the Committee charged with deciding which drugs are on the Preferred List, nor does it require that any mental health professional be on the Committee. The creation of a Clinical Drug Review Program (CDRP) would effectively create a separate PDP within the PDP, allowing the language carving out certain medications to effectively be sidestepped. Lastly, doctors would be forced to go to extraordinary lengths to prescribe non-preferred drugs, likely resulting in patients being denied access to certain medications.

It is clear from the experiences of other states that have implemented such programs that restricting access to medications within the Medicaid system has caused terribly detrimental impacts, even resulting in the death of some Medicaid recipients. Perhaps the worst scenario was that of Douglas Schmidt, a 36 year old man from Portland, Oregon, who suffered a massive seizure eight days after he lost access to the anti-convulsant he was taking. When Medicaid no longer would pay for his medication, he wound up in a coma in the hospital where he relied on machines to keep him alive for 8 and a half months at a cost of nearly \$1 million. His family was forced to make the difficult decision to remove him from life-support after Oregon decided it would not pay the \$13 a day necessary for Douglas to remain healthy.

Admittedly, the cost of prescription drugs has risen significantly in recent years. These are the same medications that have allowed individuals with mental health needs to successfully transition from psychiatric centers into communities (saving NYS billions of dollars each year), and allow these same individuals to remain healthy, productive members of our society. When restrictions are placed on these medications for the most vulnerable members of our society, the impact can be devastating.

Association of Hispanic Mental Health Professionals ♦ The Brain Injury Association of New York State ♦ The Center for the Independence of the Disabled in New York, Inc. ♦ Coalition of New York State Alzheimer's Association Chapters, Inc. ♦ The Coalition of Voluntary Mental Health Agencies ♦ Community Healthcare Network ♦ Gay Men's Health Crisis ♦ The Hispanic Federation ♦ Latino Commission on AIDS ♦ Latino Gerontological Center ♦ Latino Health Advocacy Coalition ♦ Mental Health Association in New York State ♦ Mental Health Association in New York City ♦ Mental Health Association in Westchester County ♦ National Alliance for the Mentally Ill of New York State ♦ National Medical Association ♦ The National Patient Advocate Foundation ♦ The National Kidney Foundation of Northeastern New York ♦ Urban Justice Center

December 14, 2003

The Honorable Members of the Assembly
Albany, NY 12248

Dear AssemblyMembers:

The undersigned groups are writing to express our concern about the continuing prospect of implementation of a Preferred Drug Program (PDP) within New York State's Medicaid system. We maintain, as we continually have, that it is imperative for Medicaid to continue to provide access to the medications that a patient and their doctor agree on as the best mode of treatment. Removing a doctor's judgment and providing 'cookie cutter' services to those on Medicaid is a recipe for disaster, and will only lead to higher long-term Medicaid and greater human tragedy.

Further, not only will the implementation of a PDP have dire consequences for those on Medicaid, these consequences will inordinately burden minorities, who are disproportionately represented on the Medicaid rolls. Minorities, primarily African-Americans and Hispanics, are disproportionately represented among the economically disadvantaged. According to the *Community Health Profiles* recently issued by New York City's Department of Health and Mental Hygiene, minorities are also disproportionately represented within the neighborhoods of New York City that have the worst overall health. The combination of these three factors means that a PDP will target minorities and primarily those minorities who are the least healthy individuals in all of New York City and unable to pay for medications on their own when they are denied by the state.

The poor health of communities dominated by African-Americans and Hispanics is quite clear. According to the *Community Health Profiles*, the seven neighborhoods in New York City with the poorest overall health are: Central Bronx (94% African-American or Hispanic), Central Brooklyn (91%), Bushwick and Williamsburg (90%), Hunts Point and Mott Haven (97%), Highbridge and Morrisania (95%), East Harlem (88%), and Central Harlem (87%).

When the health of individual communities is examined, these communities show the highest rates of chronic health conditions. The communities with the highest morbidity rate due to AIDS are Highbridge and Morrisania, and East Harlem (3.5 times higher than NYC average). Central Bronx, Hunts Point and Mott Haven, and Central Harlem are close behind (3 times).

An examination of the same communities reveals that all have higher than average rates of chronic disease than other communities in New York City. In fact, most of these communities, as shown in the table below, actually have the highest rate of death or hospitalization of any community in the city for multiple ailments.

As this table shows, it is not any one aspect of the healthcare arena that is suffering in these areas. Indeed, in these areas of concentrated poverty, areas in which Hispanics and African Americans are dramatically over represented, almost every measure of health is worse, and the prevalence of chronic health conditions is obviously distorted.

Community	Death rate per 100,00 people			Hospitalization rate per 100,000 people	
	AIDS	Diabetes	Chronic Lung Disease	Asthma	Mental Illness
<i>City Average</i>	22	22	21	262	671
East Harlem	76	47	35	845	1,835
Central Harlem	65	40	45	425	1,206
Central Brooklyn	54	45	22	428	1,023
Central Bronx	69	53	33	920	965
Bushwick and Williamsburg	50	47	31	991	1,042
Highbridge and Morrisania	74	50	35	708	1,005
Hunts Point and Mott Haven	69	45	25	820	792

* Numbers in bold represent New York City highest rate

The table also demonstrates that each of these chronic conditions is at its worst in the communities most dependent upon Medicaid. East Harlem has 3.5 times as many AIDS deaths as the City average. East Harlem also has 3 times the city average for hospitalizations due to mental illness, an even more amazing figure since the next closest community is only twice the city average. An individual living in Central Harlem is more than twice as likely to die of Chronic Lung disease than the average resident of New York City. Similarly, a resident of the Central Bronx is almost 2.5 times as likely to die of diabetes than the average New Yorker, and a resident of the Bushwick and Williamsburg community is almost 4 times as likely to be hospitalized due to asthma.

Unfortunately, these communities are not unique, they represent the trend throughout the city; poor neighborhoods dominated by minorities under siege by chronic health conditions. And while the data reveals the trends in New York City, advocates for the poor and minority communities in every urban area through the state will be able to tell you that these conditions are nearly universal. The economic, social, and environmental factors that are a part of everyday life in these communities have created a situation that breeds these epidemics.

The sole safety net for many of the individuals facing these chronic health conditions, the only manner by which they can receive treatment for their conditions, is often Medicaid. Placing restrictions on the medications that these individuals may receive through Medicaid is an extremely dangerous proposition, one where the Legislature authorizes Department of Health bureaucrats to enter the doctor's office and make decisions for trained medical professionals about which medications will work best for that particular patient. Doctors receive training for years so that they can make this decision effectively. Keep in mind, not a single proponent of a PDP has argued that it will improve healthcare. It is not the place of the Legislature to invade the doctor's office and remove the individual level of treatment that their patients receive in order to save a few pennies per pill, especially since that invasion will have immediate, devastating, and disproportionate effects upon specific communities.

This is especially true in light of new research by medical professionals that highlights differences in the metabolism of medications among different ethnicities and races. A study conducted by Dr. Valentine Burroughs found that individualized treatment is especially important now that the human genome project has allowed us an understanding of what causes different reactions and metabolism rates in different populations. He points out that while race and ethnicity are crude substitutes, they are the best method for conducting this research given the resources and knowledge base that we currently have available to us.

Dr. Burroughs' study found tremendous differences in the manner in which different groups process different medications. For instance, the ACE Inhibitor Captopril has a much higher effectiveness in Caucasians than African-Americans. Similarly, Asians have been found to experience greater and more severe side effects with the anti-depressant Clomipramine. Similarly, Asians require a lower dosage of the anti-psychotic medication Clozapine, and suffer a higher degree of Central Nervous System side effects from the medication.

Similar studies have come to the same conclusions. Another study found that, given the same dosage of the cardiovascular drug nifedipene, Mexicans had a blood level of the drug three times greater than other populations.

One researcher even concluded that these differences exist throughout the same ethnicity or race. For instance, it was noted that medications metabolize at different rates amongst Mexican Americans, Puerto Ricans, and Cubans due to the different ethnic ancestries. This merely confirms the point that every individual is different, with different biological factors that will influence how their body processes and metabolizes a given medication.

The poor health of minority communities, combined with the high need for individualized treatment, shows irrefutable proof that doctors need to have every treatment available to them when they decide what to prescribe to whom. If the Legislature were to place restrictions upon these medications via a Preferred Drug Program of any kind, they would be playing doctor for millions of New Yorkers without knowing all of the facts that need to be taken into consideration when a prescription is written.

It is for this reason that the undersigned groups strongly oppose a Preferred Drug Program and urge you to do the same. We ask that you talk to the Speaker, as well as your peers, and convey to them your opposition to this proposal along with your reasoning.

We are at a crucial crossroads in this state, one where we must decide if we are going to let the possibility of saving pennies on the dollar impact the quality of medical care that people receive. We hope that you will support us in agreeing that it should not.

Sincerely,

Antonio Almoguera Abad, MD
President
Association of Hispanic Mental Health Professionals

Judith Avner
Executive Director
The Brain Injury Association of New York State

Susan Dooha
Executive Director
The Center for Independence of the Disabled in New York, Inc.

Marvin R. LeRoy
President and CEO
Coalition of New York State Alzheimer's Association Chapters, Inc.

Phillip A. Saperia
Executive Director
Coalition of Voluntary Mental Health Agencies, Inc.

Catherine M. Abate
President and CEO
Community Healthcare Network

Ana Oliviera
Executive Director
Gay Men's Health Crisis

Lorraine Cortés Vázquez
President
Hispanic Federation

Dennis deLeon
President
Latino Commission on AIDS

Mario E. Tapia
President and CEO
Latino Gerontological Center

Dennis deLeon
Coordinator
Latino Health Advocacy Coalition

Joseph A. Glazer
President and CEO
Mental Health Association in New York State, Inc.

Michael B. Friedman
Public Policy Consultant
Mental Health Association in New York City, Inc.

Michael B. Friedman
Public Policy Consultant
Mental Health Association in Westchester County, Inc.

J. David Seay
Executive Director
National Alliance for the Mentally Ill of New York State

James M. Christian, Sr.
Director of Government Relations, Health Policy & Regional Coordination
General Counsel
National Medical Association

Nancy Davenport-Ennis
President and CEO
National Patient Advocate Foundation

Carol Ann LaFleur
Executive Director
The National Kidney Foundation of Northeastern New York

William Lienhard
Director, Mental Health Project
Urban Justice Center



2005 Legislative Briefing Book

Electroconvulsive Therapy Patient Protections

Electroconvulsive therapy (ECT) is a procedure that involves the application of electrical current to the brain of a patient to produce a grand mal seizure in an effort to treat certain mental illnesses. ECT has been used for many years, primarily as a treatment of last resort when all other treatments had proven ineffective, but it has become an initial or mid-level treatment in recent years.

ECT is an extremely controversial procedure, with both its effectiveness and its side effects hotly contested. Proponents of ECT claim that it is a safe, effective procedure with no permanent adverse effects. Opponents contend that ECT has no effectiveness and causes brain damage, permanent memory loss, and death. Claims about death rates from ECT proponents range from 1 in 10,000 people who receive the treatment, while opponents claim that 1 in 200 die from ECT.

The Food and Drug Administration (FDA), which has regulatory authority over ECT machinery, considers ECT machinery to be Class III, pre-market approval devices. The FDA states that, "Class III devices are those for which insufficient information exists to assure safety and effectiveness solely through general or special controls . . . (and) are usually those that support or sustain human life, are of substantial importance in preventing impairment of human health, or which present a potential, unreasonable risk of illness or injury."

In a survey conducted by the NYS Commission on Quality of Care for the Mentally Disabled (CQC), the commission found that the protocols for the administration of ECT varied amongst the five state-operated psychiatric centers that offer the procedure. Upon its findings, CQC recommended the establishment of a Blue Ribbon Task Force to establish procedures to ensure the consistent and safe application of ECT in all state-operated facilities. In addition, CQC recommended the utilization of best practices and the strict adherence to the laws and regulations designed to ensure the safety of patients and their rights.

The NYS Office of Mental Health's (OMH) activities surrounding ECT were generated in large part by legislation vetoed by the Governor in 2002. That bill, which was introduced as part of a comprehensive package of bills, intended to provide additional protections for patients considering or receiving ECT, would have mandated reporting on various aspects of ECT administration in New York. OMH's activities surrounding ECT during the past two years have satisfied the requirements of that legislation, even in the absence of the statutory authority of law. In addition, their efforts have gone above and beyond the bill's requirements to include many of the issues addressed in the other legislation, even though they never even made it to the Governor's desk for consideration. Now, OMH is working toward release of a document to help individuals considering ECT make an informed choice.

While a great deal of improvement has been made, patient protections for those considering ECT must be seen through to completion.



2005 Legislative Briefing Book

Prison and Jail Reform Involving Individuals with Mental Illness

- **Briefing Paper – Ensuring Access to Medicaid for those Leaving Jails and Prisons**
- **Briefing Paper - Elimination of Solitary Confinement for Individuals with Mental Illness**
- **MHASC supporters**



2005 Legislative Briefing Book

Access to Medicaid for those Leaving Jails and Prisons

Increasing numbers of individuals with mental illness and chemical dependency are getting caught up in the criminal justice system. Many of these individuals are often enter the criminal justice system and are discharged repeatedly. When released from correctional facilities, they are frequently left without access to the medications and services they need to remain healthy, stable and/or addiction free.

While many barriers exist in the efforts to provide individuals who have been released from these facilities with necessary services or medications, the first barrier to accessing services and medications is eligibility. Without the ability to pay, individuals released from correctional facilities who need treatment, counseling or medication are unable to qualify for programs that are designed to assist them.

New York does not follow the Federal directive, stating that, "Unless a state determines that an individual is no longer eligible for Medicaid, states must ensure that incarcerated individuals are returned to the Medicaid eligibility rolls immediately upon release, thus allowing individuals to go directly to a Medicaid provider and demonstrate his/her eligibility," (Tommy Thompson, Secretary of the Department of Health and Human Services, October 2001). Instead, individuals previously Medicaid eligible are removed from the Medicaid rolls and must re-apply when they are released. Such applications can take between 90 and 180 days.

Therefore, legislation should be enacted to require applications for medical assistance to be filed for individuals coming out of state prisons no less than 90 days prior to the expected date of release, and on behalf of individuals in county jails within the first 7 days of confinement for any inmate sentenced to more than 30 days.

Individuals without access to services eventually resort to hospital emergency room care because it is guaranteed to everyone, regardless of ability to pay. When the individual does become Medicaid eligible, all costs incurred by the individual dating back to the time at which they applied for Medicaid are reimbursed, including emergency room care, which is the most costly of all health services. Such legislation would therefore help to control the state's Medicaid costs by providing the individual with the access to the appropriate services and treatments they need upfront, rather than having them resort to hospital emergency rooms.

Additional costs must be shouldered by many public programs, including Medicaid, when individuals become symptomatic or recidivate. If necessary services and medications cannot be obtained by such individuals in a timely manner when they are released, expenses increase greatly and end up costing more taxpayer dollars in the long run. Furthermore, consistent treatment is crucial to the fullest possible recovery. Interruptions in treatment often cause setbacks that take months, and sometimes years, for individuals to fully recover from.

Without access to services and treatments, New York can expect individuals with mental health and chemical dependency needs to continue to circulate in and out of correctional institutions and hospitals in even greater numbers.



2005 Legislative Briefing Book

Elimination of Solitary Confinement for Individuals with Mental Illness

In most correctional facilities, disciplinary segregation, or solitary confinement, is commonly used not only for maintaining the safety and security of inmates and staff, but also as a means of punishment. Variations in the degree of confinement exist, the most well known referred to as 'Special Housing Units,' or 'SHUs,' or 'The Box.' Sentencing to one of these units typically entails 23-hour solitary lock down, with dietary limitations.

Disturbingly, this form of punishment is used much more freely with individuals living with mental illness than it is for the remainder of the prison population. While 11% of the state's prison population is deemed mentally ill, 23% of those in the SHU population are living with a mental illness. Further, nearly one-third of the prisoners in SHUs have been previously hospitalized in a psychiatric facility, one-half suffer from depression, and almost 30% are diagnosed with either schizophrenia or bipolar disorder.

DOCS reports that the average length of stay in such confinement is 5.3 months, while the Correctional Association's recent report told of an average cumulative sentence to solitary confinement to be 36 months. The Correctional Association accounts for this difference by detailing that DOCS does not count consecutive sentences meted out for behavior while in lockdown. Reports have recently surfaced about one prisoner with mental illness who has been sentenced to solitary confinement for 35 years.

Such disciplinary segregation is highly inappropriate for inmates with mental illness. Often times, behavior resulting from untreated mental illness causes these inmates to act out, resulting in segregation from the general prison population. Estimates place the number of prisoners with mental health needs at approximately 1,000; however, the state only has the ability to treat 200 individuals at a time in its sole secure psychiatric hospital. Instead, the state resorts to solitary confinement, a form of treatment that is far from therapeutic, as its recourse for dealing with this population. In fact, even those inmates who are not mentally ill when placed in solitary confinement are often diagnosed with some mental illness once placed in the SHU.

Working in a broad-based coalition of advocacy groups, the Mental Health Alternatives to Solitary Confinement (MHASC) coalition, MHANYS has helped push this issue to the forefront as one of the top issues facing the Governor and Legislature this year. MHASC hopes to see enactment of A.3926 (Aubry) / S.2207 (Nozzolio) into law this year, to prevent the placement of individuals with mental illness in disciplinary lock-down and ensure that they get the mental health services and treatment they need.



Mental Health Alternatives to Solitary Confinement (MHASC) List of Endorsers

Alliance for Inmates with AIDS
Alliance for the Mentally Ill of St. Lawrence
Valley
The Association for Community Living
Capital District Center for Independence, Inc.
Center for Alternative Sentencing and
Employment Services
Cephus Attica, Inc.
Coalition for the Homeless
Community Access
Correctional Association of New York
Correctional Educational Consortium
Disability Advocates
Family Justice
Howie the Harp Advocacy Center
Human Rights Watch
Latino Commission on AIDS
Legal Aid
Legislative Action Coalition on Prison Health
Mental Health Empowerment Project
Mental Health Association in New York State
Mental Health Association of New York City
Mental Health Association of Westchester
National Alliance for the Mentally Ill – Buffalo
and Erie County
National Alliance for the Mentally Ill –
Champlain Valley
National Alliance for the Mentally Ill – Chemung
and Steuben Counties
National Alliance for the Mentally Ill – Finger
Lakes
National Alliance for the Mentally Ill – Hope
National Alliance for the Mentally Ill – New York
City Metro
National Alliance for the Mentally Ill – New York
State
National Alliance for the Mentally Ill – Mid-
Hudson

National Alliance for the Mentally Ill – Queens-
Nassau
National Alliance for the Mentally Ill – Rochester
National Alliance for the Mentally Ill – Ulster and
Dutchess Counties
National Alliance for the Mentally Ill –
Westchester
National Association of Social Workers- New
York State
New Connections and Rehabilitative Services
New York Association of Psychiatric
Rehabilitation Services
NYC AIDS Housing Network
New York State Defenders Association, Inc.
NYS Council for Community Behavioral
Healthcare
Northern Franklin Public Defender’s Office
Office of the Appellate Defender
Prison Families of New York
Prisoners’ Legal Services of New York
Restoration Society
TARA National Association for Personality
Disorder
Thorpe Family Residency, Inc.
Urban Justice Center
Urban Pathways, Inc.
Venture House
Women’s Prison Association & Home, Inc.



2005 Legislative Briefing Book

ANTI-DISCRIMINATION CAMPAIGN

Based on statistics from the President's New Freedom Commission Report on Mental Health, one out of every two individuals with a serious mental illness does not seek treatment. According to the report, one of the major reasons that individuals do not seek treatment is the stigma associated with mental illness.

The stigma of mental illness is pervasive in many different arenas. This stigma is often perpetuated in the media through television and movies that often portray individuals with mental illness as "crazy" or "psychopaths."

Recent examples of this kind of stigma include the Vermont Teddy Bear Company's production of the *Crazy For You* bear, which came complete with its own commitment papers. Despite the furor raised about the bear by mental health advocates throughout the country, the bear stayed on the market through Valentine's Day. Other examples include the popularity of the sweat shirt and tee shirt that reads, "Psych Ward." There are many other advertisements and products that poke fun at individuals with mental illness which are exceptionally pervasive in the media.

Until we eradicate the stigma of mental illness, many people will remain in the shadows and not receive the treatment that will help them move forward toward recovery.

Therefore, we recommend the creation of a tax check off on the NYS Income Tax return form that would be dedicated for an anti-stigma public awareness campaign that would be administered through a state agency and funding would be provided to organizations on a Request For Proposal basis.