New York State Attorney General

Public Hearing on Access to Mental Health Care in New York

June 22, 2022

LETITIA JAMES: Good afternoon, everyone. I would ask everyone in the room to please silence their cellphones. My name is Letitia James, and I'm the Attorney General in this great state of New York.

The past two-and-a-half years have challenged all of us in immeasurable ways. Our lives have been upended. We've lost more than 1 million individuals in this country from COVID including family members, friends, and neighbors, and we've all struggled in some way with the mental health impact of this crisis, whether anxiety and stress brought on my fear, grief, or social isolation, our preexisting mental health illness exasperated by these conditions and an increasing lack of access to critical care as a result.

Allow me to provide you with an overview of the problem as well as a historical background. New York is in the midst, my friends, as we all know of a mental health crisis which has been exasperated during the COVID-19 pandemic.

Decades-long decline in New York's supply of short-term inpatient psychiatric beds

in an important part of the continuum of care was accelerated by the pandemic during which hundreds of beds were taken offline or converted to COVID-related or general medical use.

Similarly, community-based care has been drastically under-resourced and robust outpatient care is inaccessible to many. As COVID-related hospital visits decline, emergency departments are overwhelmed by individuals who required more intensive psychiatric services but are unable to access necessary psychiatric inpatient beds or services in the community.

The objective in this hearing is to shed light on this crucial issue to explore potential areas of reform and to guide future investigation into allegations of inadequate mental health treatment.

Now, allow me to give you a historical background. The move to de-institutionalize psychiatric care started in the 1960s inspired by the concerns about the civil liberties of people with disabilities and public outcry of public -- at horrible conditions in psychiatric residential institutions like Willowbrook.

The Americans With Disabilities Act in

the 1999 Supreme Court Decision in Olmstead v. L.C. later consecrated into law the principle that individuals with disabilities should be treated in the most integrated setting in the community appropriate to their needs.

More recent movements to move from institutionalization to community-based services has been largely driven by cost and efficiency concerns with low Medicaid reimbursement rates considered a primary factor in incentivizing hospitals to close these beds.

Governor Pataki created the commission on healthcare facilities in the 21st Century known as the Berger Commission to identify ways to reduce state medical spending and recommend right sizing of hospitals and nursing homes.

The Berger Commission's 2006 report ultimately recommended reducing inpatient capacity at 48 hospitals, including about 4,000 beds through restructuring and closures.

2014, Governor Cuomo accepted an $8 billion federal medical redesign grant to establish delivery system reform incentive payment program, DESRIP, and created the transportation plan under the Office of Mental

Health to reduce both the census and beds at state psychiatric centers.

Over the next five years, DESRIP embarked on an ambitious plan to transform the state Medicaid program and to use financial incentives to promote efficiency and reduce preventable hospitalizations including psychiatric hospitalizations by 25 percent.

Nearly one-third of state psychiatric hospital beds reserved for children were cut. The policy's stated intention was to shift funding to outpatient community-based treatment but evidence does not show a commensurate increase of these programs.

Moreover, data shows that since 2014, the number of seriously mental ill people in homeless shelters, jails, prisons, and on our streets has increased, and I don't think we need any data for that. This phenomenon has been called transinstitutionalization.

And so, according to the New York State Office of Mental Health, there are only about 3,000 beds at hospital and state institutions across the state and children are not immune to this crisis.

According to the great research from the city and ProPublica, and I want to thank them both, in the past 10 years the number of residential treatment facility beds for children has been cut in half, 554 in 2012 to 274 this year for the entire state of New York.

Children desperately need inpatient emergency care, and according to the State Department of Health, there were 12,738 visits to the emergency department for self-harm in 2018 including 4500 by young people for self-harm under the age of 19.

And while we don't have statewide data yet, that number has undoubtedly grown since the pandemic. The CDC reported 31 percent increase in mental health-related emergency department visits amongst adolescents in 2020 from 2019, and there are not enough accessible, community-based services that provide the care needed to prevent hospitalization.

And so, when a child is in crisis, parents or caretakers have only two options: go to the ER, call 9-1-1, and too often as we've seen in our office, they've had run-ins with the police that only make the situation that much

worse.

These children are waiting months and months for treatment. I personally have gotten calls from frantic family members of children in my neighborhood who were self-harming but they weren't able to secure a bed and safe space for them.

Hospitals have cited financial pressure, specifically cuts in Medicaid reimbursements, as one of the main reasons for the decrease in beds and the closure of facilities.

In the absence of this care, we've seen an over-dependence on emergency room visits and a situation reaches a breaking point, usually resulting in an individual being released from the hospital far too soon and with no outpatient services to support them and/or follow-up, only to come back in the emergency room days, weeks, months, or years later. It's a revolving door of short-term, Band-Aid solutions. Without critical life-saving care, too many individuals are unable to hold a job. With the loss of reliable income, many end up on -- many end up homeless on the streets, shelters, and in our jails.

As Dr. Xavier Amador, an expert on schizophrenia, said in a recent New York Times article, people do not fall between the cracks. In our mental healthcare system, they are pushed between the cracks. They're pushed out the door and there is an abyss, and that's why we're here today, to figure out where government is failing people and how we can address these serious challenges to ensure that no one is being pushed through the cracks and that instead of a dark abyss there is a supportive, accessible safety net of care.

So, today we're hoping to get some answers. What happened to the beds and how can we get them back? Where's the action to eradicate barriers to accessing these services? How are we addressing issues of capacity, insurance coverage, staffing, and the defunding of programs? What are we doing to help individuals who are homeless? Why is community-based care so drastically under-resourced and robust outpatient care inaccessible to many? What are we doing to increase Medicaid reimbursements?

And today, we're going to try to get

answers to these questions and many more that are fueling this crisis in care, and one of the questions that I have is why is the HHS, health and hospitals, receiving all of the individuals who are struggling with mental health? What are the private hospitals doing?

We will be looking at the entire system, and we'll do that by hearing from advocacy groups, healthcare providers, and government agencies, but we'll also hear from members of the public who live with and care for individuals with mental illness.

Already we've gotten written testimony of so many New Yorkers with personal stories like Erin from Suffolk County who describes the struggle with trying to find quality mental health care providers that insurance so you don't have to pay out of pocket or Chris from Staten Island who told us a story of having a mental health episode and when he went to a hospital, the staff didn't know how to properly help him, or Jessica from Buffalo who gave heartbreaking testimony about not being able to find long-term supportive housing and other resources for her sister who lives with paranoid schizophrenia.

I want to thank them for their courage for telling their story and everyone else who is participating in this important hearing today, whether you were here in person providing testimony remotely or in writing or simply tuning in from home. Your time, your experiences, and your insight is critical to our efforts.

I want to note that we did invite the State Department of Health and the State Office of Mental Health to testify today. They have offered to submit testimony, and if we receive it before the end of the hearing, I will read it into the record.

This is one of the most pressing challenges that New Yorkers are facing, people who must live through mental health crises each and every day deserve to be seen and heard. They deserve to be listened to and they deserve answers, but more importantly they deserve service.

This hearing is about exploring potential areas of reform and informing my office for future investigations into allegations of inadequate mental health treatment or the lack of (indiscernible).

My office will thoroughly review everything that is said here today and we will act independently, transparently, to seek answers and to ensure that the truth is laid bare, because in this time of extreme stress, devastation, and pain, and given all of the homeless that we are seeing each and every day that we try not to look at, that we oftentimes ignore, we must ensure more care, not less, for those seeking the help that they need and recognize that mental illness is not a crime and should not be treated as such.

Before we begin, I want to introduce Jennifer Levy, First Deputy Attorney General; Megan Fox to my left, the Chief Deputy Attorney General of Social Justice; and Gina Bull, Assistant Attorney General and Special Assistant to the First Deputy Attorney General, who I must say has worked on this from day one, and I appreciate her and I thank her for her commitment. She's been with me for a very long time and this has been her passion.

And they will be here throughout the hearing to help ask questions and to basically retain information that will assist in our

follow-up actions in the weeks and months ahead. I'd also like to take this time to acknowledge Assistant Attorney General Michael Riceman of our healthcare bureau. He's unable to be here today because he's doing the work of the angels. He's currently in Poland volunteering to support Ukrainian refugees. It's my honor and my privilege to lead an office where so many people care about others before they care about themselves. He's leading our investigations into these issues and has done a lot of the planning for this hearing. We thank him for his work and we pray his safe return.

Now, Abby, I'm going to turn it over to you. You'll provide the rules and process for today's hearing and introduce the witnesses. Thank you.

ABISOLE FATADE: Thank you, Attorney General James. Welcome. My name is Abisole Fatade. I will be the parliamentarian for today's hearing, meaning I will be responsible for the timing and the flow of today's proceedings.

Just some just quick overview. Each individual making a statement or testifying will

have an allotted amount of time to speak, which you may have been apprised of before you entered here today. There's a countdown clock visible to both the panel and the individual speaker such that they can monitor their own time.

I will give a 30-second warning, this high-tech piece of paper, so that the speaker can begin to conclude their testimony, and after a speaker is done, there will be time for questions and answers, if any, both individually and in small groups.

Before we start, have you both been sworn in? Great, thank you. So, I'll like to welcome Alice Morrisey and Dr. Tony Carino. (Indiscernible).

ALICE MORRISEY: Good afternoon. My name is Alice Morrisey and I'm representing BronxWorks, a social services organization with over 30 years' experience in homeless services.

Under contracts with the New York City Department of Homeless Services, we currently provide outreach and case management to over 1500 people experiencing homelessness in the Bronx.

Homeless individuals living with mental illness are not inherently dangerous. Of the

thousands of New Yorkers who fall through the cracks of other medical and social service systems and into homelessness, there is only a very small number who at times pose a direct threat of harm to themselves or others.

In these rare instances, BronxWorks looks to the support of New York City hospitals with inpatient psychiatric units, but too often we have experienced situations in which they appears to avoid admissions from our clients.

In one recent example, BronxWorks advocated for inpatient psychiatric care following multiple incidents where a client had threatened to take his own life and had caused bodily harm to others. The hospital ultimately refused to admit this individual stating in an e-mail that he would "jeopardize the safety of our staff and other vulnerable patients."

The hospital also declined to arrange for admission at a facility that had the resources to meet his needs or to begin the application process for assistant outpatient treatment, although this is something that, by all accounts, can only be achieved by hospitals. When hospitals refuse to take on a patient, we

currently have no opportunity for recourse or escalation. Even when we can obtain a psychiatric admission for a client, we have found many hospitals unwilling or unable to coordinate on care.

Years ago during a period of extreme winter weather, BronxWorks obtained admission for a street homeless client who had routinely been at risk of hypothermia after refusing to seek or accept appropriate shelter. The hospital discharged him before he was stabilized and despite his continued refusal of outpatient treatment or housing assistance.

Prior to discharge, the hospital's clinical staff had explicitly noted in his chart that the client was "actively psychotic without insight and with impaired judgment." Still, the hospital declined to pursue any application process for AOT or a transfer to a longer-term inpatient facility.

BronxWorks licensed social workers contracted psychiatrists and the client's own family members had attempted to get care for this individual for years, but the attending psychiatrist advised that he should be "left

alone" at his street location.

On many occasions after making the difficult decision to hospitalize a client, we have learned about discharge only upon discovering that the client has returned to street or shelter.

The absence of appropriate and well-coordinated psychiatric care can lead to poor health outcomes up to and including death as well as increased criminalization of mental illness. This past winter, community members in Manhattan's upper west side repeatedly called 9-1-1 to request help for a homeless woman who was regularly seen laying down in the street and presenting in clear psychiatric distress. In January, she was struck and killed by a car.

A few weeks earlier, a man with a history of homelessness and mental illness pushed a woman to her death on a New York City subway track. He now faces second-degree murder charges.

New York City continues to lose licensed inpatient psychiatric beds and low reimbursement rates for inpatient stays effectively incentivize hospitals to discharge

psychiatric inpatients sooner.

Because of the shortages, patients who can secure beds are often admitted at facilities far away from their communities making it difficult for any existing support systems or care teams to coordinate on care and discharge.

We have tried for years to collaborate with hospitals to find long-term care solutions for the very small number of clients whose mental health needs require higher levels of care. In our written testimony, we have detailed potential areas of reform to ensure there is accountability for providing quality, accessible care for all New Yorkers.

Thank you for this opportunity to present testimony today.

ABISOLE FATADE: Thank you. And now we'll hear from Dr. Carino. Please proceed.

DR. TONY CARINO: Good afternoon. My name is Dr. Tony Carino. I'm the Director of Psychiatry at Janian Medical Care in CUCS.

For the last 14 years, I've provided psychiatric care to people experiencing homelessness in New York City. We work hard to provide care in the care gaps of people with

serious mental illness.

I provide care currently through a homeless outreach team and an ACT team in the Bronx and I lead a team of psychiatrists that are attempting to provide care in the care gaps.

I'm speaking today because my patients oftentimes can't advocate for themselves due to homelessness and their mental health conditions, so I'm here to speak on their behalf, and I'd like to start by saying that people with mental illness respond to care and treatment, and I've seen barriers to care, and humane care, that could really help and support them.

I'm going to provide an anecdote and provide some recommendations. One of our ACT patients went missing for a day. We called local hospitals and located him at a Bronx hospital. He had fallen in the community and was being treated by medicine with a psych consult service.

We called the medicine team and the psychiatry consult, explained that he was on a life-saving medication, clozapine, and it needed to be continued. He'd been stable on it in the community.

The clinicians agreed to start the

medication. We had these calls multiple times throughout the day. They did not restart the medication. After day three, our director went to the hospital, provided his pills from the community, and provided that to the inpatient team. They continued to not restart the medication.

I called the director of psych consult service who said that medicine was completed with their inpatient care and he was not homicidal or suicidal, and despite being off his medications would be discharged to the community and he couldn't be psychiatrically admitted.

We then met with him right after discharge, evaluated him, and he was experiencing psychosis and psychiatric decompensation, and we coordinated transfer to his -- to another inpatient hospital where he got care for this new psychotic episode.

We've also had multiple occasions during the pandemic of hearing that, psychiatric beds are no longer available in the city, and multiple patients have been sent out of the city many miles away where we can't coordinate care well. Psychiatrists and psychiatric inpatient

teams don't know New York City's services, and it's very difficult to actually communicate with them.

We think that there is some key steps that could really improve care. First of all, ERs and inpatient psychiatrists could -- should communicate with outpatient treating psychiatrists and clinical teams. There's a database called PSYCKES where they can access us with 24/7 services -- 24/7 phone services when there's clinical treatment teams.

Number two, we need inpatient bed capacity. And the type of bed capacity needs to be more appropriate for mental health. Currently it's acute care, only a few days. Extended care units are indicated and important and there's only two of them in the city.

Number three, there needs to be more crisis beds to prevent hospitalizations. Mental health symptoms oftentimes occur and precede a psychiatric emergency. There are support and connection centers and other crisis beds but those need to be accessible and we need to be able to refer as community psychiatrists to them. We currently can't refer to them.

LETITIA JAMES: Thank you. Ms. Morrisey, it's really unacceptable that a hospital would fail to stabilize a patient when expressing threats of harm to themselves and/or others. What -- did they give you a reason why they refused to stabilize this patient?

ALICE MORRISEY: In this particular example, the attending psychiatrist said that the client was too disruptive and posed a risk to her other patients and staff, and there was also some disagreement between that psychiatrist and the outpatient psychiatrist as to whether or not medication would help the individual in that particular instance.

LETITIA JAMES: Ms. Morrisey, do you have any recommendations? Are they included in your testimony?

ALICE MORRISEY: Yes, I do have recommendations included in my testimony -- my written testimony.

LETITIA JAMES: Thank you so much. And Dr. Carino, what role does insurance play in a hospital's decision to discharge a patient so quickly -- too quickly?

DR. TONY CARINO: So there's two ways

that it impacts. The first way is just that hospitals have incentives -- really unfortunate incentives to close psychiatric units and reallocate them. So, we've lost psychiatric beds to outpatient orthopedic units, for example, or acute surgical interventions that reimburse higher. So, there's that wider issue, but also there's incentives to discharge more quickly.

As I was saying, oftentimes patients need more than the 4 to 12 days of inpatient care, especially with homelessness and physical health complexity. And so, the insurance disincentive beyond a few days really pushes inpatient teams to discharge soon.

LETITIA JAMES: And to either of you, to what extent is it lack of training, insurance, Medicaid reimbursement, or just a failure to recognize the symptoms? What is the -- what would you say is the issue if you had to pinpoint?

ALICE MORRISEY: I think it's a combination of a lot of factors. I think one piece, though, that maybe could be highlighted is the fact that, you know, in emergency rooms and hospital settings, those physicians are asked to

look at, you know, that one point in time and the way that that individual is presenting in, you know, in this exact moment, this person in front of me, are they posing a risk to others. And there isn't as much opportunity currently I think for outpatient providers, whether that be psychiatrists, social workers, family members, other people who are seeing them on a daily basis and might be able to provide a more holistic picture as to what the current circumstances are and as to why this care might be needed.

DR. TONY CARINO: There's resource limitations. In the hospital there's workforce challenges as well in which more of the work force needs to be supported and brought into the hospitals and a capacity as Alice says to actually have the inpatient and the ER teams communicate with folks that know and the treating providers that know people really well and have known them oftentimes for years and can provide the clinical history that's essential for good decision-making and good medical care.

And since the COVID pandemic has subsided somewhat, Have these beds that were offline, have they come back online for

psychiatric patients as far as you know?

DR. TONY CARINO: Some have been reallocated again and sort of come back online. I don't know the current state of how many of those beds were regained and how many had been lost permanently throughout the pandemic.

ALICE MORRISEY: Yeah, I can't speak to that. I'm not -- I'm not aware.

LETITIA JAMES: And do you think homeless individuals are treated differently from others who are seeking care in hospitals or individuals who are -- who have mental health episodes and who happen to be homeless?

DR. TONY CARINO: People experiencing street homelessness are more likely to get poor care, to be thought of -- their cases as hopeless or not as responsive to treatment. Our experience is that people experiencing homelessness do respond to treatment when they're provided with psychiatric care, housing, and psychosocial supports. They can live fulfilling lives, connect with family, obtain employment, and stay in permanent housing when they have access to care.

ALICE MORRISEY: I would say yes. I

think that there can be a perception that individuals who are experiencing homelessness are malodorous. They are perhaps disruptive. And so I think there's challenges given that. I also think sometimes the fact that someone doesn't have an address can be a barrier to certain types of care.

I know specifically with assisted outpatient treatment, not having an address can be a barrier to successfully obtaining that. And I think just oftentimes not having family members to advocate for them I think is also a huge barrier to care.

LETITIA JAMES: And when beds were limited during COVID, well, beds are limited in general but when they were even more limited during the COVID period, where were individuals sent? you said they were sent outside of New York City. Where exactly?

DR. TONY CARINO: One example would be Brunswick Hospital in Long Island. And so, there were -- often times we would have to call frequently, sometimes calling the director of psychiatry to have them call back the inpatient treating team. And one of the challenges was

they just didn't have as much familiarity with New York City services, less awareness about assisted outpatient treatment, about the city services, about some of the discharge planning that's really essential. And it was a real shame that New York City with so many resources was sending patients out.

We also had to explain to family members who oftentimes visit or call and support their loved ones in the units that their loved ones would be sent multiple miles away where they wouldn't be accessible at all to family members.

LETITIA JAMES: Was there any coordination, New York City and on Long Island?

DR. TONY CARINO: Well, we -- my team are very persistent. We know when the change of shifts are. We call repetitively. We call consistently and we escalate when we need to. And we get -- we ended up having case conferences and calls. What I worry about is what about those people with mental illness that don't have a team of psychiatrists that's calling in this way and advocating in this way? What happens with them?

LETITIA JAMES: And were the services

on Long Island more robust than they were in the city?

DR. TONY CARINO: That was not my experience, no.

ALICE MORRISEY: I would defer to Dr. Carino's testimony on that.

LETITIA JAMES: Okay. Any questions? Thank you for your testimony. I appreciate it.

ABISOLE FATADE: Hello, welcome. Before we start, please speak closer to the mic. They're having issues with our livestream. Thank you.

Before we start, have you guys -- you all been sworn in?

NADIA CHAIT: Yes.

ABISOLE FATADE: Okay. Thank you. We will begin with Nadia Chait. Please proceed.

NADIA CHAIT: Good afternoon. I'm Nadia cheat. I'm the director of policy and advocacy at the Coalition for Behavioral Health. We have as our members about 100 mental health and substance use providers throughout New York City and New York State. Our members provide the full array of outpatient services, everything from clinic-based treatment to assertive

community treatment, substance use programming, supportive housing and care management.

And I want to start by saying that we are fully committed to the reality that people with mental illness can live in the community safely and successfully, but there are times when just like your physical illness might be exacerbated to a level that it requires an inpatient hospitalization, someone with a serious mental illness may need hospitalization to deal with what they're experiencing.

And so, our members work closely with their clients to avoid that reality but also to support them when it does happen. Unfortunately, however, we experience a number of difficulties when it comes to accessing inpatient care and advocating on behalf of clients who need that level of treatment.

I'm sympathetic to the fact that hospitals face many of the same challenges that community-based providers face from inadequate Medicaid reimbursement rates, managed care challenges and pressures, the reality that commercial insurance companies have simply never fully covered our services at parity with

physical healthcare, and a workforce crisis that is across our sector and absolutely makes it harder to serve our clients in the community and in hospitals every day.

However, we feel that often when we are advocating for our clients to be admitted, the hospital staff are not responsive to and don't really respect the impact -- the input that the community-based provider has. We see our clients for years and long tenures. When we're saying that someone is decompensating, that they're experiencing an increase in psychiatric symptoms to require a hospitalization, we're saying that based on a real knowledge of their illness that is difficult to match in a quick emergency department observation, and so we would really like to see more understanding and more collaboration between those who are making the admissions decisions with the providers who really understand what the client is experiencing.

We also find that discharge planning is often lacking. It's critical for our providers to be very engaged in discharge planning, to know what medication changes have been made, other

treatment recommendations, and to know that the client has been discharged, but often our -- particularly our housing providers report to us that the only reason that they knew that the client was discharged was because they came back to the housing program.

But what if they didn't? The provider wouldn't have known that they need to be out in the street looking for that person, finding where they are, bringing them to safety, re-engaging them in care. So, discharge planning is so critical to ensuring that folks don't fall between the cracks.

And I think there's also efforts that could be done through PSYCKES, a database that was mentioned before, to make that more real time. It tends to have a lag, often a significant lag, to really help ease some of those communication challenges. Thank you.

LETITIA JAMES: Thank you.

ABISOLE FATADE: Thank you. Now we'll hear from Nicole McVinua. I hope I did your name justice.

NICOLE McVINUA: Yes, thank you.

ABISOLE FATADE: Please proceed.

NICOLE McVINUA: Good afternoon Attorney General James and distinguished members of the panel. My name is Nicole McVinua, and I'm the director of policy at Urban Pathways. I thank you for the opportunity to testify today.

Urban Pathways is a nonprofit homeless services and supportive housing provider that has been serving the New York City community since 1975. We assist single adults through street outreach, drop-in center services, safe havens and supportive housing. Our supportive housing programs include (indiscernible) licensed extended stay residences and permanent supportive housing.

Many of the people we serve live with serious and persistent mental illness. We serve about 3900 New Yorkers in need annually. We have seen an increased challenge getting our clients access to mental health -- to mental healthcare in both outpatient and emergency settings. These challenges have significantly increased since the onset of COVID-19 while mental health and substance use concerns have worsened.

Access to outpatient psychiatric care for low-income individuals has become exceedingly

difficult to access. The number of psychiatrists who accept Medicaid is extremely limited, leading to long wait lists and limited appointment times, which leave our clients waiting for weeks and sometimes even months to be seen.

Because of their limited capacity, most psychiatrists accepting Medicaid require individuals to come to two or three intake appointments before they can even become a patient, and this can be an arduous process for somebody who's living with a serious mental illness that's sometimes difficult for them to complete. And when an appointment is missed, they're told they have to restart that intake process.

The high cost of mental health care makes it impossible for people with low incomes to access a provider who does not accept Medicaid, leaving them with few options. And when care is accessed, it's notable that it's often lower in quality. New York desperately needs more psychiatrists who are accessible to low-income people on Medicaid.

When a person is experiencing a mental health crisis, there are significant barriers to

accessing emergency care. The typical response to a mental health crisis call is still 9-1-1 and police are sent, and while there have been and continue to be efforts underway to remove police from mental health crisis response, access to alternatives are still not as widespread as are needed and none are available 24/7. This leaves NYPD responding to the vast majority of mental health crisis calls which usually result in somebody being handcuffed, even if they're being transported to the hospital, which is an extremely traumatic event and ultimately makes the person feel criminalized for having a mental health emergency.

When mental health crisis requires immediate response and leads to the emergency room, our clients are often not held for observation and are sent back the same day unless they're actively demonstrating symptoms of psychosis while they're in the ED, and this has become worse since the pandemic due to the shortage of beds.

Our clients regularly arrive back at their residence without communication or paperwork from the hospital regarding their

discharge plan or the result of their visit, which leaves staff completely in the dark as to how to best assist this individual, and they're often told that it's because of HIPAA compliance that they can't respond. And while we recognize, you know, the importance of HIPAA, more consistency in asking the person to sign a release form if they're comfortable or improving communication would allow for a better continuity of care. Thank you very much for the opportunity to testify.

LETITIA JAMES: Thank you.

VICTORIA PHAM: Good afternoon Attorney General James and the distinguished panel. Thank you for giving me the opportunity to testify before you today. My name is Victoria Pham, and I am a chief medical officer at the Institute for Community Living, ICL, a New York City-based nonprofit that serves about 14,000 individuals a year including many with very serious mental health issues and substance use disorder.

I'm also a board-certified adult and child psychiatrist who has been working at many different levels of care, including inpatient psychiatric units. The issue we are here to

discuss today are ones that I have seen and witnessed over the years.

I'm very grateful to the state for its commitment to addressing mental health systemic problems but clearly much more is needed to ground the skyrocketing mental health crisis. I will outline a few key junctions within the (indiscernible) system where I think focus is needed.

Number one, inpatient psychiatric beds has been decreasing over the years while demand has been increasing. This has led to a very long wait time in the ER. It's not unusual for someone who needs an inpatient bed and waiting in a gurney two to seven days for an inpatient bed due to shortage.

While they wait, they often stay in the hallway and just using the bed as their home for the next few days. It's wrong. The impact of quality care and prolong and complicate -- this impacts quality and complicates treatment.

As a psychiatrist, I work night and weekends at two inpatient units for the past 13 years. One facility closed down its inpatient psychiatric unit due to COVID and has converted

to surgical and medical beds, and another facility, which is a state facility where I continue to see children in the inpatient unit, and I must say that it's so beautiful in terms of the care and services that they are receiving.

Often times, it's not about therapy or medication but it's really giving them a rehabilitation environment to be different than what they're used to at home. Some of these children have survived a lot of trauma, and I truly believe inpatient really is so helpful for them to really have a chance to live a different life.

Number two, increase funding for different levels of care that are closer to inpatient, such as impatient crisis stabilization, residential respite, and supportive crisis stabilization. This alleviates emergency room wait time and decreases the need for inpatient services.

Number three, like many have mentioned, we need a HIPAA compliant care coordination system that communicates in real time among hospital systems, outpatient services, criminal justice systems, and substance abuse programs.

This will help with smooth transition and continuity of services.

Increased telehealth services in all level of care, including telephonic use. I can tell you many of my Medicaid patients, they don't have smartphone, they don't have good Wi-Fi plan and they cannot navigate Zoom or any of the HIPAA-compliant platform. So I will spend 30 minutes just to get them on Zoom and really never get into the core of things. So, I think telephonic is so, so important.

And lastly to target very focused population. A few of those examples would be those who recently were discharged from the hospital within 30 days or those who had at least four emergency room visit for the same indication or condition within the last year. Those are highly evidence-based sort of options. Thank you for giving me the opportunity to appear before you today.

LETITIA JAMES: Thank you, Doctor, for your testimony and the entire panel, but obviously I can -- I feel your pain and recognize how close you are to the issue, and I really want to thank you for coming here today.

The fact that individuals who go to emergency rooms three and four times as you mentioned, and the fact that there is evidence which suggests that they need a comprehensive plan, that they need more inpatient attention, what happens in those types of situation? How do -- how does the medical profession deal with that and/or how does your organization deal with individuals who tend to present themselves at emergency rooms over and over again? Where do they get the care?

VICTORIA PHAM: Typically what happens is that these individuals may not meet the criteria for inpatient, so they would -- they may not be admitted into the inpatient levels of care.

They often come for a number of psychosocial needs, such as they need support for housing, they need food, they need outpatient care that is not outpatient but more intensive like medical respite or crisis respite and so on.

So, people come to get solutions, but often times in our system, we focus mental health solutions as medication and therapy alone. But I would highly emphasize the need for social

determinant of health solution such as a jacket, a bed, food. Those are things that people also come to the ER for and we only think of like, you know, inpatient outpatient meds or therapy.

LETITIA JAMES: So it's more holistic. You also mentioned that, and I don't think this is an issue that has been given a sufficient amount of attention, and that is your population oftentimes it's not familiar with Zoom, don't have access to the internet. They don't have smartphones, and so as far as you know, does anyone offer any telephonic services to individuals to get them telehealth?

VICTORIA PHAM: We do. During the COVID waiver -- COVID emergency waiver, telephonic is allowed. But once the COVID waiver expires in October it is an open question, but we're really hoping for things to move toward that direction. It is for the patient's benefit because otherwise I'm not sure how someone could like, you know, get their services if they're at home, for example.

LETITIA JAMES: And the waiver that you're referring to is a state waiver, federal waiver?

VICTORIA PHAM: It's a state waiver.

LETITIA JAMES: State waiver.

NADIA CHAIT: If I could jump in on that?

LETITIA JAMES: Sure.

NADIA CHAIT: The state has published as emergency regulations the OMH regulations will -- they're in emergency effect and we're waiting for them to be, you know, permanent, but permanent regulations that will allow telephonic care to continue --

LETITIA JAMES: Okay.

NADIA CHAIT: -- as long as there is federal financial participation. So, it is a little bit both a state and federal issue for Medicaid, but we anticipate that the federal government will allow that for Medicaid clients. For Medicare, the restrictions -- there are more restrictions on telephonic. It can be used, but it's much more limited for clients who have Medicare.

LETITIA JAMES: And the increase in Medicaid reimbursement is also conditioned on federal funds, correct?

NADIA CHAIT: Yes.

LETITIA JAMES: So the state approved an increase in Medicaid reimbursement but they're waiting to hear from the federal government.

NADIA CHAIT: That's my understanding, yes.

LETITIA JAMES: Is that your understanding, everyone's understanding? Okay. And is the fact that patients are restrained and criminalized, does that deter you, the provider, from calling 9-1-1 for help?

NADIA CHAIT: I can say speaking for our providers that it does. It's always a complicated decision for a provider to call 9-1-1. And many of our providers have worked with the local precinct and have built relationships with certain, you know, officers so that they understand if you get a call from this location, you know, what that is, but of course there's a lot of different officers out there, there's a lot of different responses that you get.

I will say, I think, you know, the move to 988, the crisis hotline that is going to come online in a little less than a month, as long as we fund and build out the mobile services to respond to those emergencies, the promise of a

three digit number for these kinds of crises that isn't 9-1-1 is a really exciting movement, and I know, you know, speaking for the providers that I represent that that's something that they are really looking forward to, because sometimes you do need someone -- even in a clinical setting you need a response that's different from what that clinical setting can provide, especially like a supportive housing program.

You know, someone may be in crisis and they need a higher level of care than housing program is designed to offer. So they need additional resources but it needs to not be police.

NICOLE McVINUA: Yeah, and I would just add that, you know, it definitely is a deterrent but like was just said, a supportive housing agency is not really designed to meet mental health crises. Most of our staff are case management staff. They're not clinical staff, so they really don't have the capacity to deal with somebody who's having a crisis.

And unfortunately, a lot of like the mobile crisis team that New York City currently has, you know, when that team responds, it's a

good result but they are not available 24/7. They're only available from 8 a.m. to 8 p.m. So you know, we find that a lot of folks have crises later at night, overnight, when they are not as active, right, when they're sort of more isolated in their room by themselves. And so, you know, we really need 24/7 crisis response.

And mobile crisis teams also don't necessarily respond right away. So, you know, I was talking to one of our program directors who say, yeah, mobile crisis is great if they can come, but sometimes they're only -- you know, they come within 24 hours. If somebody is having a crisis, waiting a full 24 hours is, you know, very, very challenging, so.

LETITIA JAMES: Earlier, you mentioned parity. Currently, New York state and federal law require that health insurance plans cover mental health and substance abuse disorder treatment the same way that they cover all other medical treatment. Are you not seeing that?

NADIA CHAIT: So, we aren't, and it happens in a couple of ways. So, I would say first of all, on the commercial side, the rates of reimbursement for mental healthcare remain

substantially lower than they are for physical healthcare. On the physical healthcare side, Medicaid is typically the lowest reimbursement rate, Medicare is in the middle, and commercial reimburses the most, often three, four times the Medicaid rate.

In our system, the commercial reimbursement rate is typically about half. It doesn't come anywhere close to covering the full cost of care. And then also there's, you know, what are called non-quantitative treatment limits. So, the other kind of ways that insurance companies introduce barriers to accessing care in this state, just with their own Medicaid managed care plans, you know, which really should be working on behalf of the state, the most recent review of them, none of the plans were able to show that they fully complied with the state's regulations on non-quantitative treatment limits.

LETITIA JAMES: So, in 2021 -- well, let me just back up. So, you know, I'm -- you know, did research and I'm told that there's day treatment programs, there's partial hospital programs that are designed for persons with more

acute symptoms, there's assertive community treatment (ACT) teams, there's intensive mobile treatment teams which offer services by a mobile team in the client's residence or elsewhere in the community, there's assisted outpatient treatment services that can be either court ordered under Kendra's Law or voluntary comprehensive psychiatric emergency program CPEPs, which are hospital-based programs that provide crisis outreach.

I'm told that general hospitals also treat persons with psychiatric conditions on emerge -- on an emergency basis, and I'm also told that in 2021 the state enacted a law creating crisis stabilization centers that would serve as an alternative to emergency room visits for people facing mental health or substance abuse crisis to voluntary (indiscernible) services and overnight shelter. This sounds wonderful. Is this real?

NADIA CHAIT: It is real, but there's not enough of it. So, I -- and I think also it's a building process. So like the crisis stabilization centers, that RFP just closed. So they will be real, but they're not real right

now. And the ACT teams are great and the state again had an RFP out to expand those, which is really critical, but there is a wait list for those services. That's why the state needed to expand it. We didn't have the capacity to serve everyone who needed that level of care.

And that's really true across the mental health system. We've never -- you know, as a society, we've always stigmatized people who have mental health conditions and never invested in the care that they need adequately.

And so, I think very much that the state is working now to address decades of failure, but it takes time and it's happening at a time when we have a workforce crisis that is leading I will say on the part of some of our providers to not apply for some of these new opportunities that are coming online because all of their current programs have 30 percent staff vacancy, so they can't take on that expansion even though it's so needed, because they don't have the staff.

LETITIA JAMES: So years of neglect, disinvestment, we have a crisis, COVID, we're playing catch-up, so we just don't have enough

capacity to meet the need and the demand? Does that sum it up?

NADIA CHAIT: Exactly.

LETITIA JAMES: And the answer to simplify it is more resources and more organizations on the ground and hospitals got to do -- have to do a better job. And all of those beds that were taken offline need to be put online and expanded with an emphasis on peds.

Any questions from -- thank you, ladies. If only ladies were in charge. Well, for now.

ABISOLE FATADE: And I would like to welcome Senator Gustavo Rivera.

LETITIA JAMES: Welcome, Mr. Chair.

GUSTAVO RIVERA: Good afternoon, Madam Attorney General.

LETITIA JAMES: Good afternoon, sir.

GUSTAVO RIVERA: Oh, I guess the time started. Yes, I'm sorry. Yes. Good afternoon Madam Attorney General and the rest of the folks. So my name is Gustavo Rivera, state senator for the 33rd district in the Bronx and the chair of the health committee in the senate.

You have a more detailed testimony

before you. I'm just going to hit some highlights of what I think is important. First of all, I want to thank you, Attorney General, for holding this hearing. I think it's incredibly essential to kind of dig deep into these issues. I think that certainly the panel that was here before me did a good job of probably what you're going to be hearing for a lot for the rest of the day related to the lack of resources, and I will hit on some of that in my testimony as well.

The first thing I want to just briefly talk about, and the reason why I believe hearings like this are important, is because I believe that when it comes to mental health issues, stigma has been such an enormous part of how we determine policy.

Unfortunately, stigma has led for us and we -- some of the folks in the panel before me talked about it in the ways that people have mental health issues many times are treated in certain ways in our society and are kind of dismissed in certain ways in our society and the stigma that's attached to what we believe sometimes about mental health means that the

policies that we -- that we put in place do not actually address the issues in the way that they're supposed to be addressed.

So, having conversations like this is incredibly important. Now, the -- we talked about -- some of the folks here talked about access. You will continue to hear about that, I'm sure. That is a fundamental barrier to care and that is either when we're talking about availability of services or the ability to obtain those services.

The -- I think that the three things that I wanted to just underline really quickly, since I only have three minutes, there's three -- increased demand, second workforce, and third reimbursement.

On the case of -- when we're talking about increased demand, the fact is that the pandemic did a number on all of us and certainly increase the demand and certainly in the next couple of decades we're just going to see the demographic shifts in the state as well as the rest of the country, only going to make the demands go up, which puts the workforce challenge quite into perspective.

And as far as reimbursement is concerned, the state of New York unfortunately the last -- for 10 years was anything related to Medicaid or mental health or public health was kind of ruled by austerity, and we have seen the impacts of that.

I think that there are things that we're doing to kind of turn the table on that or turn the ship, although it will happen slowly. On issues of workforce, certainly the conversations that we had during the budget related to creation of more programs to create more of a pipeline for workforce and all the different workforces that deal with issues of mental health.

On reimbursements, there are some changes that we started to see on that. I still think that we need to get rid of the Medicaid global cap, which is a bill that I carry, and as far as access to services, I do think that while there were certainly telehealth -- telehealth was something that was expanded greatly, so the access to services through telehealth was expanded greatly through the pandemic and we've kind of done some things to make sure that

continues to be the case, there's far more that we need to do. And I also have a bill for that, that will actually create parity as far as services.

So I'll just -- I'll just finish by saying that all of these things are worse off with the health inequities that exist in communities of color, like the ones that I represent, and as -- and I'm glad that we're having these conversations and hopefully we'll have them for years to come.

The ship will take a right -- a long time to put right, but I'm glad that we're going in that direction.

LETITIA JAMES: Thank you. Mr. Chair, could you please briefly explain what the bill on the cap on Medicaid would do -- the bill that you're proposing exactly --

GUSTAVO RIVERA: Yes. So the Medicaid global cap was a creation of the prior governor back in the 2011 budget cycle. The idea which I certainly supported at the time was that the Medicaid costs were outpacing -- the growth of Medicaid cost was just too much, and so we tried to -- we created something back in 2011 called

the Medicaid Global Cap. It was not exactly put into law. It was something that was kind of -- unfortunately turned into a messaging point. It basically was the argument that we were able to control Medicaid costs, but instead of really taking into effect -- into full consideration the impact that this had over time by the time that we got to this year, and I certainly have been arguing this for a couple of years, not been the only one certainly, but that we need to get rid of the Medicaid global cap because it is an artificial construct that limits the growth of Medicaid on a year-to-year basis.

And so we are -- there's a bill that I have to get rid of it. The governor did make some adjustments in this year's budget and I certainly thank her for that. I believe that we're moving the right direction there, but since this has such an impact on the reimbursement rates that are received by my providers all across the state, that that in turn means that they are, you know, that they're less likely to be able to provide these services, you know, over a long term.

LETITIA JAMES: And Mr. Chair, are you

supportive of a bill on the federal level, which was introduced by Congress member Maloney? It is entitled the Michelle Alyssa Go Act, named for a woman who was tragically killed in January, which would repeal Medicaid's institution for mental disease exclusion and allow facilities with more than 16 beds to be reimbursed by Medicaid? Apparently, facilities with more than 16 beds right now are excluded from being reimbursed by Medicaid.

GUSTAVO RIVERA: This is actually the first I hear of this piece of legislation just on the face of it. It seems like something I would support. I would like to certainly look into it further, and if there's -- but if there's something we can do at the state level that addresses some similar concerns, I'd certainly like to pursue it.

LETITIA JAMES: And last question, Mr. Chair, is can the state expedite funding to increase the reimbursement rate now waiting for federal matching funds? Can -- is there something that we can do with your office to expedite that funding?

GUSTAVO RIVERA: I believe so. There

is a -- there is much that the governor can do. Certainly the budget is the key time, right? The budget and the conversation during the budget is a key time to talk about the -- obviously to talk about the funding that the state uses on a year-to-year basis. But I do believe that the governor has a lot of authority in -- even in between budgets to be able to have an impact on all these things.

And I believe that a lot of this needs to be reconsidered. During the budget time, usually when we introduce a piece of legislation, it has an impact on this (indiscernible) we're told we're going to have to wait until the budget because it's obviously a budget conversation because it's a fiscal one. But I do believe that there's much that the governor can do in this regard. And I am certainly looking forward to being back here next year or being back up there in Albany next year to talk to -- to talk to the governor about this and hopefully continue to move in the right direction.

I do think again, credit where credit is due, we -- there were 10 years of austerity before her and she is starting to turn the ship

slowly. We -- I think that we needed to yank it a little bit more but I guess that give and take is what makes for good governance, and I do believe that we're headed in the right direction.

LETITIA JAMES: Thank you Mr. Chair for your testimony. I appreciate it.

GUSTAVO RIVERA: Thank you (indiscernible).

ABISOLE FATADE: And now I'd like to welcome Council member Linda Lee.

LINDA LEE: Hello. Good afternoon. It's afternoon, right?

ABISOLE FATADE: Yes. Council member Lee, have you been sworn in?

LINDA LEE: Yes.

ABISOLE FATADE: Okay, thanks. Please proceed.

LINDA LEE: Okay. Thank you so much Attorney General James for the opportunity to testify today, and actually a lot of what I'm going to say is similar to what the two panels before me were saying.

And so, I'm the city council member representing District 23 and before serving in the council I was the president an CEO of KCS,

Korean Community Services, of metropolitan New York which is a nonprofit serving the Asian and Korean community in New York City. And while I was there, I opened -- it took me four years but I opened up an article 31 outpatient mental health clinic at KCS which still remains to be the only Korean-led outpatient clinic that's led by a nonprofit in the Korean community, and now serving as the chair on the council's committee on mental health disabilities and addictions, I'm here to talk about this very important issue and sort of offer sort of some of my thoughts on what I'm seeing and previously on the ground.

And as this hearing recognizes, we're in the midst of a mental health crisis, and you know, to be very clear, this is always an issue before. And years of disinvesting into the system has only exacerbated what we're seeing in the pandemic. And you know, multiple studies have shown increases of two to three times the reported pre-pandemic levels of depression, anxiety, and other mental illnesses.

And I would definitely say these numbers are undercounted as in my experience the studies often discount non-English-speaking

communities and folks that are not being reached through these surveys in very hard-to-reach communities.

And so given the breadth and severity of this problem, I wanted to highlight just four, maybe more, factors that I believe are necessary to solve the ongoing mental health crisis, and these are all things that have been previously stated.

So, the first, I just want to echo the increasing of the state's mental health systems capacity by increasing the number of inpatient psychiatric beds currently available and improving the continuum of care for patients.

And people with serious mental illnesses need treatment to recover and left untreated their conditions are likely to exacerbate over time, and therefore we must reverse this decades-long disinvestment and downward trend in the inpatient psychiatric bed supply.

And the other thing I wanted to highlight is -- the second thing is we need to better coordinate care between private, nonprofit, federal, state, local government and

providers to ensure patients don't fall between the cracks, and that includes ensuring a smooth rollout of the new 998 -- 988 national mental health hotline, which was previously stated before.

And I heard that if you -- and there was an article in the city that came out that said if you have a non-New York City area code, you have to dial the full number. So, I don't know if that's going to be a temporary thing in the beginning of when the rollout happens, but that's something that was brought to my attention yesterday.

And so I think, you know, seeing the rollout is going to be important and how that's implemented, and I think what I'm facing also at the city council level is that there's tons of silos. So you have state, for example, just if you take the mobile treatment teams. Their state-level mobile treatment teams and there's multiple of them depending on what, you know, service specific is required, and then on the city level you have some of the mobile emergency response teams that are housed with Department of Homeless Services, DOHMH, EMS, you know, the Be

Heard as well as, you know, that's under the mayor's office and my -- what I've seen is that it's not just about more resources, but it's about coordinating the services better between different agencies, and I think that's going to be really key in addressing this issue.

And something that you've heard also is of course the extremely low rates of insurance reimbursement and Medicaid reimbursement for mental health care, which often falls below the minimum threshold necessary for adequate treatment. And one study found that New York Medicaid paid doctors only 44 percent of Medicare rates.

And this is what I find incredibly insane is that New York City's employment -- employee insurance plan has not updated its rates since they were set in 1983. So, we're looking at reimbursement rates that haven't been updated in years, and this is definitely problematic because, you know, as a former mental health care provider, I can tell you that the costs of reimbursement are too low to the point where you're dis-incentivizing people from providing these services and going into the sector to work

and also the clinics and especially the outpatient cares.

You know, they're having to have their staff argue with Medicaid all the time because Medicaid is trying to not pay and we're trying to advocate for the patients to get them treatment. And so, we're constantly arguing with insurance companies to make sure that they get reimbursed.

And also, I think it would actually be interesting to look at -- because preventative care we all know saves the city and state dollars. And so, I'd be curious to know -- to think creatively, how can we also see if there are some non-clinical services that insurance companies would be willing to cover that we know are evidence-based like the peer-to-peer, family-to-family services, for example, (indiscernible) NAMI New York City is one example of an organization as well as other models, like Fountain House where they have the clubhouse models.

So these are all things that I think creatively we can look into. And then of course, lastly, the workforce issue which, you know, if not addressed in the near term will definitely

limit our ability to provide services at a time when the federal government and state and city are finally starting to make adequate investments.

And a lot of the providers are facing about 40 to 50-percent turnover and 30-percent vacancies due to the low number of qualified staff graduating into the field and historic attrition due to low pay, stressful work, and relatively better conditions in the private sector.

And just on a personal note, I know that as running a nonprofit where it was so hard for me to find bilingual mental health professionals, like, we're not able to pay them at the same rate as hospitals, for example, which I know hospitals are desperately needed there, too. And so we're almost creating this system where we're competing with each other, and you know, I think we need to increase the COLA -- the cost of living wages, make sure we have pay parity so that folks in the nonprofit sector, preventative service sectors are also getting paid what they need to get paid in the field.

And so, that's something that I just

would love to advocate for. I know in the city for the first time we've invested 60 million into the COLAs. I don't think it's enough. I think we need to make sure that we're continually investing in, you know, the social service sector.

So, I will stop there, but I just want to thank you so much for inviting me to testify here today.

LETITIA JAMES: Thank you. So, Madam Chair, is there a bill that's been introduced in the city council to coordinate services on the city level?

LINDA LEE: Well, we're trying to first see what can be done, and you know, I think -- I think there's a real opportunity with the new mayors of office of Community Mental Health, and I think they are creating -- it's not necessarily a bill, but I think, you know, they have started to create tasks for -- task forces or have done so in the past, and I think we need to continue that conversation to see how these different city agencies are continually communicating with one another to ensure that there is an efficient way to know what the right and the left hand is doing

from one another.

That is something that we are thinking about doing in terms of the legislative process as well, is sort of saying this is something that we think, you know, would be good for you guys to do on a regular basis and perhaps mandating that, and so -- and it's not just that, but I think the other challenge on the city level, which you know well as well is that different city agencies require different reporting and different compliance. And so, that's also a challenging piece as well.

And I will say this is where I think it's key to coordinate between the city and the state, because the city may have the funding and the resources, but all of the compliance regulatory licensing pieces are with the state.

And so, we have to make sure that those, you know, the city and state are working hand in hand together as well.

LETITIA JAMES: And where would an individual who's suffering from mental illness, who does not speak -- English is not --

LINDA LEE: -- organization is creating a mental health directory in multiple languages

for a lot of different communities, because even if --

(Audio skip)

LINDA LEE: -- they do groups, they have, you know, they have social clubs, they have those types of events and they have social workers on staff. It's just not a licensed program, but those things are still very much needed and then they are the ones that actually have reaches into referring those clients to the hospitals and to other treatment services if they're needed.

LETITIA JAMES: And the COLA increase that was included in the budget, does that extend to individuals who work in this industry, in this profession?

LINDA LEE: Yes, it does.

LETITIA JAMES: Very good.

LINDA LEE: Although I would argue we need more. I'm always going to advocate for more.

LETITIA JAMES: That was my next question.

LINDA LEE: Yeah.

LETITIA JAMES: Any other questions?

Thank you, Madam Chair.

LINDA LEE: Thank you.

ABISOLE FATADE: Now I'd like to welcome Andrea Smith, Alice Bufkin, and Ron Richter. Feel free to share the mic and move in closer. Have you all been sworn in?

ALICE BUFKIN: Yes.

ABISOLE FATADE: Okay. Alice Bufkin, will you please proceed?

ALICE BUFKIN: Good afternoon and thank you to the Attorney General and this panel for holding this very important hearing. My name is Alice Bufkin. I'm the associate executive director of policy for Citizens' Committee for Children. We're a multi-issue children's advocacy organization dedicated to ensuring every New York child is healthy, housed, educated and safe. We also helped coordinate the Healthy Minds Healthy Kids campaign, which is a statewide behavioral health coalition for children.

This is a critically important hearing because if you talk to families or you talk to behavior health providers as you're doing today, they'll tell you the same story. Things are desperate out there. Children are presenting at

younger and younger ages with serious mental illness. Families are blocked at every stage from finding care. Young people are cycling in and out of ERs and hospitals because they can't get the care they need early.

COVID-19 has clearly and acutely escalated these needs. But the foundations were there well before the pandemic, driven by chronic under-investments in the children's behavioral health system, deeply inadequate reimbursement rates, and a focus on crisis intervention instead of prevention and the full continuum of behavioral health supports.

The focus of this hearing is on individuals with serious mental illness with a particular emphasis on the closure of inpatient psychiatric beds. My written testimony addressed some of these issues impacting these facilities, largely emphasizing the need to implement proposed rate enhancements immediately and really appreciate that question earlier, Attorney General, provide interim supports to facilities when they're closing to ensure continuity of care for families, and requiring health plans to address network inadequacy.

However, I think it's important that this hearing is not restricting its focus only to what's happening in out of home placements because that obscures the larger landscape that's driving the need for and lack of intensive services.

The reality is that children struggle to access care at any level which only leads to an escalation of need and a reliance on RTFs and psychiatric beds which as this hearing has established are deeply inadequate to meet the need.

So with that in mind, I want to touch on a few recommendations. First, we need to take stock of the state's redesign of the Children's Medicaid system. The transformation rolled out in 2019 was intended to increase capacity and access to home and community-based services in order to reduce or eliminate the need for out of home care. It was a large part of the justification for the closing psychiatric hospital beds, but those services haven't fully materialized. And in fact, the data we have suggests that we may be serving fewer children and with a less robust array of services.

Our state needs to assess where children and families are being left behind and develop a robust and fully funded strategy to fulfill the promise of increasing the number of children receiving behavioral health care in homes and communities, reducing the number of children requiring services in more restrictive settings.

More generally, we need to invest more in the children's system. This year's state budget made some critical investments in behavioral health, including to an array of rate enhancements.

We are very grateful to these investments and they lay an important foundation. With that said, the children's system has been starved for years and we have a lot of ground to make up.

The state must also invest in programs and services that work across the continuum of a child's life. This requires reforming rate methodologies to help ensure rates are sufficient and conducting the annual assessment of the viability of clinical rates, and the frightening reality that we've heard earlier is that there's

simply not enough providers to meet the deep and widespread needs in the state. Building the state's behavioral health workforce must be an urgent priority. In particular, we need to identify strategies to increase the number of multilingual providers and providers of color. This includes strategies like educational -- reducing educational debt of new practitioners, establishing loan forgiveness programs and scholarships, and providing college credit for on-the-job experience and learning.

And finally, we need to help -- hold health plans accountable for enforcing mental health parity, which they are negligently in violation of. In sum, we can't address the long-term challenges with out of home services if we don't address the chronic challenges across the system and deliver on the promise to provide comprehensive community supports to children in need. So thank you again for holding this hearing.

LETITIA JAMES: Thank you so much.

ABISOLE FATADE: And now I'd like to ask Ron to please proceed.

RON RICHTER: Good afternoon Madam

Attorney General and others.

LETITIA JAMES: Hello, Commissioner. It's great to see you.

RON RICHTER: Nice to see you, too. So, I am here on behalf of JCCA, which is a large children and family services organization celebrating its 200th anniversary of serving New Yorkers, and in particular has a therapeutic foster care program and a residential campus in Westchester where we serve children that are particularly high needs.

We have about 17,000 clients, but in particular we're focused on the 200 children that we serve in Westchester County that come from throughout New York state. Some of those young people require medication and significant psychiatric treatment which we address on our campus, which is called a residential treatment center and is licensed by the New York State Office of Children and Family Services.

As New York has seen a dramatic drop in the use of residential care in the child welfare system, namely there were 50,000 children in care in 1990, there are now 8000 children in care. There were 35 percent of them in residential care

in 1990. There are now less than 9 percent of those about 8000.

We are seeing the children with the highest acuity in residential care. Many of the children that are in our care on our campus experience psychiatric crises where they need to be taken from our campus to a hospital in order for the hospital to evaluate what they are experiencing.

So recently a child left our campus with our staff in suit and stood in front of a vehicle on a highway seeking to have the -- a car approach and kill him. This is not an unusual occurrence.

The police arrived with our staff and we stopped the incident from happening. That child requires immediate psychiatric evaluation and admission. That is not happening in Westchester County in New York.

We have had experiences where Westchester Medical Center has refused psychiatric evaluation repeatedly, and I don't use Westchester Medical Center to call them out. I use it to say that these emergency rooms are unable to evaluate young people because they're

overwhelmed and they are afraid to admit young people into their ER because then they have no place to discharge these young people to.

There are simply not enough psychiatric beds for children that are suffering. So, while the community in Westchester was extremely distressed that this happened, at the same time that young person is struggling mightily with a mental illness that we are caring for and mostly treating well. He's mostly doing fine, but this happened because of his illness.

He had a visit at home and he didn't take his meds for the weekend, and these things happen. It shouldn't result in him not getting the care that he needs in the state of New York, and that's happening repeatedly.

So, what we would ask is that the governor, you know, increase her investment which was a phenomenal 28 million this year, clearly there needs to be more, and that organizations like JCCA be supported in caring for children that 30 years ago we probably wouldn't be caring for.

But in addition to the reduction in psychiatric beds, the state has dramatically

reduced OMH's residential treatment facilities so that organizations like JCCA are now caring for children that have significant psychiatric illness.

I really appreciate you doing this hearing. It couldn't be a more important subject. And I'll just end by saying things like Buffalo and Texas with children getting killed are happening when we had the warnings about young people who are struggling mightily and end up harming others. We don't want to see that happen ever again, and we know the warning signs. We just are not affording the treatment.

LETITIA JAMES: Thank you.

ABISOLE FATADE: Thank you. Please proceed.

ANDREA SMITH: I'm Andrea smith, the president of the New York State Coalition for Children's Behavioral Health. Thank you for holding this very timely hearing.

You have my submitted testimony. It's five pages of incredibly and annoyingly detailed history of the residential treatment facility and the shrinkage of the capacity for children's mental health services.

In the conclusion of that piece, I summarize that a child living in Erie County on paper would have the best opportunity to access children's mental health services given the array. But I sit before you wearing orange to remind us all that gun violence, witnessing violence, and the childhood loss of a caretaker are adverse childhood experiences that impact the development, the economic achievement, and the lifelong health outcomes of individuals unless they're addressed immediately. So in this way, we all know that Erie County does not have enough resources to meet the needs of the community at this time.

In the remaining time, I'll carry the voices of family members who could not be with me today. And I encourage you to plan additional hearings in other locations so more family representatives can share the anxiety, the anger, and the helplessness they feel about a system that fails them over and over and over again. So, these vignettes are in those families' voice.

My child waited five months for RTF placement. Her admission was delayed because of staffing shortages. I fear my child's discharge

from the RTF. There are no educational placements, and I'm -- or community services in place and I'm afraid the gains in wellness will be lost without services. How can I manage his needs and behavior on my own when he has 24-hour care at a residential treatment facility?

My child was discharged suddenly from an RTF because of safety issues and violent harm to others. We spent three months waiting in an emergency department before a safe appropriate placement was arranged.

My child is ready to be discharged from the RTF but I am wracked with anxiety because there aren't any community services available and we're being told we may have to wait four months before they can be admitted -- my son can be admitted to a clinic or home-based care. Without the supports in place, I'm forced to choose between working and caring for my child.

So, in summary, safe and out of home services were precipitously downsized without the necessary investment into community-based care. The situation has persisted for over 10 years and we have multiple recommendations in our written comments to bring immediate relief.

LETITIA JAMES: Thank you so much. First, let me say, Ms. Smith, we are -- we do plan on having hearings in upstate New York and in Hudson county. So, you can be assured that this is just not a one off. I thank you for that.

And for Mr. Richter, as you know, the law requires -- both federal and state require hospital emergency departments to provide appropriate medical screening and stabilization to anyone who presents themselves at a hospital with an emergency medical condition.

That young child presented himself with an emergency health condition. So, was Westchester County in violation of the law or is there an exception in the law with respect to individuals who may present violent tendencies?

RON RICHTER: So, suffice to say, Madam Attorney General, that we are looking into the question that you just asked. In some cases we are finding ourselves bringing young people to Bellevue, which does evaluate and in some cases admit our kids on the campus, but it is certainly an area that we are pursuing and have our own general counsel looking into the question you

asked.

LETITIA JAMES: So let me just say that again, if anyone presents themselves and unfortunately they do not receive services any at facility anywhere throughout the state of New York, please contact my office. There is a form on the website, and I urge everyone to fill it out so that we can again look at these complaints to determine whether or not individuals are complying with the law.

Ms. Bufkin, did I say that correctly? You said that the children's system is being starved. How long has it been starved and what are some of the factors -- what are the reasons why it's been starved?

ALICE BUFKIN: Yeah, I mean, I think for a very long time, I don't know if I could pin a particular date on it, but you know, when we think about the composition of our Medicaid system, when we think about how we're putting our funding, and Medicaid children are getting a fraction of that funding overall, even though they represent a huge portion of the Medicaid population.

So some of it is about budget decisions

in terms of where we're putting our state funding, because all of this that we're talking about is really about prevention. How do we -- ideally we want to be getting services to both adults and young people well before they have need for out of home placements, but the reality is we're not investing in that full continuum of care.

So rates are, as you've heard -- I don't need to go into extensive detail, but that is a key piece of it. And then also when we look at the transition of children's Medicaid into managed care, you know, as we know, managed care's bottom line is not necessarily serving children. It's profit. And so, you know, we see a disjoint between what the needs are of children and sort of how our system is framed, and it's not necessarily lining up what the reimbursement rates are in terms of the reality of what it takes to keep facilities open and serve children with the most, you know, robust and comprehensive services that they deserve.

LETITIA JAMES: Is a managed care system addressing the needs of individuals who are struggling with mental illness, including but

not limited to pediatric patients?

ALICE BUFKIN: Not adequately, no.

LETITIA JAMES: Is that the sentiment of everyone on this panel? And we want to give credit to Governor Hochul. She did include in this year's budget an increase in Medicaid reimbursement. We're waiting for the federal government. I hope all of you will join with me in expediting that approval process from the federal government.

ANDREA SMITH: I do believe that the governor can issue an executive order that not withstands the clause that requires federal financial participation and release the state funds and then collect the federal financial participation when the approval is forthcoming.

Making providers wait, we are still waiting for release of the American Rescue Plan funds, waiting for us to wait when the federal government has already approved the state plan amendment so that it can go through an internal state approval process is just -- doesn't make any sense with the crisis we're in.

LETITIA JAMES: You believe all of those funds can be released through an executive

order?

ANDREA SMITH: I think that they can -- the state can frontload state payments and then collect the federal financial participation retroactively.

LETITIA JAMES: Thank you.

RON RICHTER: I would -- I would say that in terms of solutions, and you requested them, our state Office of Mental Health has not issued any request for proposals with their existing funding to offer families in communities with kids that have high acuity any evidence-based models that have been proved to work.

For example, functional family therapy, multi-systemic therapy, services that in New York City we have been offering to keep kids out of upstate placements since 2006, our State Office of Mental Health offers none of them while they have reduced all of the residential treatment facility beds.

It is completely confusing, confounding that our State's Office of Mental Health doesn't offer these mental health models that have evidence behind them that could help families function better. That's their design.

None of us understand in the provider community or the advocacy community why our State Office of Mental Health wouldn't be offering the opportunity to families in the state to have these programs.

LETITIA JAMES: Do they offer any models other than the emergency room?

RON RICHTER: Our State Office of Mental Health, I probably -- I don't want to answer that they don't offer any models. They've just introduced Youth Act teams which is brand new. So, we're hoping that those will help kids be at home with high acuity, but I don't know that they offer any evidence-based models. I would defer to the others if they are aware of any.

ANDREA SMITH: The funding is included in the budget but again has not been released. So it is another example of something that needs to be expedited.

LETITIA JAMES: And do both of you believe that funds can be front-loaded through an executive order? I know -- I know your position. Do the other two panelists agree with that?

ALICE BUFKIN: I think so, yes.

LETITIA JAMES: Okay, okay.
RON RICHTER: I'm not sure.
LETITIA JAMES: Okay, thank you. Any questions from the panel?
JENNIFER LEVY: I just --
GINA BULL: Go ahead.
JENNIFER LEVY: No, you go.
GINA BULL: Mr. Richter, I wanted to ask if you are aware of any parents who have had to voluntarily place their children in foster care in order to get their children adequate mental health services, inpatient care?
RON RICHTER: I am not personally aware of any, but I am aware that that is a challenge for some parents and that they have sought placement through the voluntary system in child welfare in order to get the right placement for their kids. So, I could probably find you a parent or two. I don't personally know a parent that's done that.
LETITIA JAMES: So let me just say this to the audience. If anyone surrenders their child to the childcare system in order to get services, please contact our office. If they believe that the only way to get mental health

services is through the foster care system, they should reach out to our office.

RON RICHTER: Right. So, if I may, what happens is that they are going to an agency with a very ill child and they are seeking the right kind of supports and what ends up happening is someone, you know, refers them to a child -- to the child welfare system and they are told if you sign a voluntary you will get the right placement. That's happening to answer your question. But you asked if I know of a parent. I don't personally know a parent, but it's certainly an issue and one way for a parent to get the right placement. So we have voluntarily placed kids on our campus. And in all likelihood it was either resolved because the choice for the parent was you're going to be brought to court on some sort of neglect charge or you can -- you can do a voluntary.

LETITIA JAMES: And because the population has decreased over time, you have more capacity now. Is that fair to say?

RON RICHTER: Quite the contrary. We are, you know -- it's somewhat complicated, but we don't have -- we don't have enough foster

homes even though we have so many fewer foster children. Part of it is how challenging the kids that we have that come into care are, how high needs they are.

LETITIA JAMES: More acuity.

RON RICHTER: Yeah, I mean the kids that we have on our campus right now, we would love for them to be in foster homes. And there are a lot of advocates who think they should all be in foster homes.

I was at a graduation this morning of our -- for our Edenwald program, and you know, the children really struggle. It's -- you know, their families are there at the graduation. Some of the families want their kids to be in a program that can really support them when in fact the families struggle supporting their kids at home.

LETITIA JAMES: Thank you. Thank this panel. I appreciate it.

ABISOLE FATADE: Now I'd like to invite Commissioner Ashwin Vasan. Afternoon Commissioner. Have you been sworn in?

DR. ASHWIN VASAN: I have, yes.

ABISOLE FATADE: Thank you. Please

proceed when you're ready.

DR. ASHWIN VASAN: Okay.

LETITIA JAMES: Hi, Commissioner. Howa are you? Sorry.

DR. ASHWIN VASAN: Hello. No worries. Good afternoon, Attorney General James. I'm Dr. Ashwin Vasan, the commissioner of the New York City Department of Health and Mental Hygiene.

LETITIA JAMES: Thank you for being here.

DR. ASHWIN VASAN: I appreciate you having me. Thank you for the opportunity to testify today on access to mental health care for people with serious mental illness in New York state.

First, I'd like to acknowledge the context of this timely and important discussion and conversation on mental health, collective trauma, isolation, and resulting mental health impact faced by New Yorkers over the last two years as a result of the COVID-19 pandemic on top of our pre-existing mental health crisis, which has been highlighted.

According to NYC Health Department data rates of depression and anxiety continue to be

elevated from pre-pandemic Levels. In 2021, a quarter of New York City adults reported symptoms of anxiety and 18 percent reported symptoms of depression.

Mental health impacts will continue to rise as we experience the long tail of this second pandemic. I'm very grateful to Mayor Adams for bringing me into this administration to lead on the issue of mental health, which is a first for a Commissioner of Health and Mental Hygiene.

The city's mental health strategy is a true public health approach, one that centers equity, evidence, innovation and upstream policies and interventions as well as downstream care and support.

It's grounded in population-level goals and objectives, recognizing that the results of our efforts will be told not just by the clinics we staff and the projects we build but by the impact we have on the well-being and mental health of New Yorkers. And this extends especially to people most impacted by mental illness, people with serious mental illness, one of the most impacted populations by COVID-19 and

as we work across city agencies with community partners and providers to provide lifesaving care and to connect New Yorkers with social and economic supports they so desperately need.

Over 250,000 New Yorkers are known to have serious mental illness or SMI, that is a mental health condition that's serious enough to affect their daily functioning. Up to 40 percent of these New Yorkers are disconnected from most or all forms of care, instead living isolated in their homes or more worryingly on shelter -- in shelters, on streets, or in our correctional systems.

New Yorkers with serious mental illness are among the most socially and economically isolated members of our community. This isolation leads to cumulative neglect, and when combined with the stigma and discrimination they face from society as well as from health care systems has led to disproportionately poor health outcomes.

Across the country these individuals live -- lose up to 25 years of life dying prematurely and disproportionately from cardiovascular disease, stroke, sepsis, tobacco-

related diseases, and cancers. Recent studies have also found that SMI independent of any other drivers is among the top risk factors for poor COVID-19 outcomes and death.

To begin the effort to fundamentally shift the way we care for these New Yorkers, we must start by shifting away from the idea that all people with SMI are doing is simply moving from crisis to crisis and can only be helped with acute care and hospitalization.

This perception has been created and perpetuated by the persistent lack of access to stable community-based alternatives to care, treatment, and support which are in and of themselves crisis preventive.

Make no mistake, during a crisis access to acute care is necessary, but we must shift towards a model of crisis prevention and long-term recovery and support in the community and not simply in institutional settings.

So, what does this look like in practice? I find it helpful both in my experience as a physician and an epidemiologist as well as in my previous leadership of Fountain House, an organization that supports people with

serious mental illness, to think about three fundamental pillars or legs of a stool that allow people to stand and find dignity and hope. Those pillars are housing, health care, and community itself.

We must ensure -- we must ensure that people with SMI have permanent affordable homes with health and social supports available through supportive housing. The health department contracts for permanent supportive housing for tens of thousands of people with behavioral health concerns who were previously chronically homeless. And as announced in Mayor Adams' housing plan, we are committed to streamlining access to supportive housing to further reinforce this prevention strategy.

Of course, we must also address gaps in acute mental health care and psychiatric bed access. And in order to do so, we must address access to long-term, community-based behavioral health care that addresses SMI and addiction as the chronic illnesses they are.

In doing so, we must identify the multiple and intersecting issues that have led to a progressive shrinkage in state-run psychiatric

beds over the last decades while artificially constraining the role of private and other nonprofit hospitals in expanding access to inpatient psychiatric care.

The Institutions for Medical Disease or IMD exclusion, which has been in place since Medicaid and Medicare's enactment in 1965 has dis-incentivized hospitals and other treatment facilities from building more than 16 inpatient psychiatric beds and has prevented Medicaid from reimbursing for this type of care, restricting facilities from building more beds and restricting access to inpatient care as a result for those who need it the most.

We're of course encouraged by the governor's attention to this issue -- to the former issue and efforts to increase state psychiatric capacity, a system which has also taken a major workforce hit during COVID-19.

Underlying all of this is a structural issue of lack of parity and reimbursement between behavioral and physical healthcare, which drains billions of dollars from our mental health systems that could be invested back into recruiting and retaining more mental health care

workers and expanding access to care.

The sad truth is that lack of reimbursement parity drives psychiatrists, psychologists, and other behavioral healthcare workers into private practice where they do not have to address issues like SMI and they don't have to staff inpatient psychiatric wards.

Addressing these structural issues will require serious and sustained partnership with the state and federal government, and I'm optimistic that we have the conditions in place for just such work over the coming weeks, months, and years.

Finally, housing and healthcare do not advance sustained recovery unless paired with efforts to build community and to break social isolation for people with SMI, which is ultimately the driver of poor health and neglect. Recovery-oriented mental health systems rooted in community and connection requires investment in places where people can come together to break isolation, otherwise known as social infrastructure.

Social infrastructure includes places where people can build community and social

isolation, develop connections to vital services, to opportunity, and to purpose for themselves. These places save lives. They prevent crises and they set -- they serve to set people on paths of recovery and learning to live with SMI. Our city's support and connection centers, for example, provide a short-term alternative to criminal justice responses for individuals who might have a significant mental health or substance use need and need help getting back on their feet.

At the center, people will get access to everyday needs like clean clothes and food along with counseling, connections to mental health and substance use treatment in communities where those services are needed the most.

And our mental health club houses across the city also provide critical long-term anchor institutions for individuals with SMI to build relationships, to get access to resources, find employment and educational opportunities and build supportive peer communities to help them navigate the ups and downs of living with a chronic, serious mental illness.

Our continuous engagement between

community and clinic treatment connect program provides an innovative model of mental health treatment whereby clinics through local and community partnerships will directly address and respond to social factors that can negatively impact mental health such as involvement with the justice system or housing insecurity.

This level of support aids and promotes services and prevents people from falling through the cracks while referred between systems, which happens all too often for this population.

And in all of this work we're committed to meeting people where they are. This includes expanded access to intensive mobile treatment or IMT teams, evidence-based teams which provides sustained treatment and support to individuals in their community where they are most comfortable. IMT offers mental health, addiction services, peer specialists who provide treatment and support including medication and facilitate connections to housing and other supportive services.

These are big structural and systemic changes that must happen in order to improve the mental health landscape and save and improve as

many lives as possible. And we, at the city level, are committed to working concurrently on the levers that are in our control and partnering quietly or advocating loudly for the ones that are not.

I'll close by mentioning that our strong relationships with both the Hochul and Biden administrations have renewed optimism for collaboration on data driven public health and (indiscernible) mental health policies. We've already seen investments in policy improvements from both administrations, including an expansion of AOT, including increased reimbursement rates for psychiatric hospitalizations and loan repayment for psych professionals and other important mental health investments in our state budget, as well as renewed support for harm reduction and mental health at a federal level.

We're excited about this unprecedented renewed and intergovernmental focus on mental health, particularly from the federal government, and have been working hand in hand with the Biden administration and our state partners on these priorities, including the rollout of the new 9-8-8 crisis hotline.

We're excited to make New York City a model for 9-8-8 implementation building off of our strong foundation of digital and telephonic services created by NYC (indiscernible).

This is a historic and unique moment in mental health. It's central to the public health agenda of our city and our country. We're uniquely ready to meet this challenge. Thank you again for your partnership and support and for your commitment to the health and well-being of New Yorkers and I'm happy to take your questions.

LETITIA JAMES: Thank you, Commissioner. Just a few questions. I'm familiar with Fountain House and I'm also familiar with the clubhouse model, which is evidence-based.

In the budget that was just recently passed, are there additional funds to expand upon those services in the city of New York?

DR. ASHWIN VASAN: We're always looking for additional funds and we'll be making a few announcements about this shortly at the appropriate time.

LETITIA JAMES: Are you in support of the bill that's been introduced by Congresswoman

Maloney with respect to the IMD exclusion that you mentioned?

DR. ASHWIN VASAN: Very supportive. Yes. And I was out publicly speaking about that, the Michelle Go Act, I think you're referring to.

LETITIA JAMES: Yes. As far as you know, has Senator Schumer sponsored it in the Senate?

DR. ASHWIN VASAN: I'm not aware but I can get back to you.

LETITIA JAMES: Okay. We will reach out to Senator Schumer in support of that IMD exclusion, which is really critically important, so that individual facilities with 16 beds or more can have access to Medicaid reimbursement and Medicaid funding.

The lack of parity that you mentioned and the reimbursement, what is the city doing with respect to the effort by this -- Governor Hochul to increase Medicaid reimbursement, but unfortunately the federal government has not put forward -- has not supported it or has not approved it and has not put forward the required federal funding?

DR. ASHWIN VASAN: We're very grateful

for the increase in reimbursement rates. You know, the issue with parity is that we actually have good laws.

LETITIA JAMES: Yes.

DR. ASHWIN VASAN: We're just not enforcing them, and actually New York is better off than most states in terms of parity enforcement, but we're still not at true parity. We're I think somewhere near 80 cents on the dollar, which is much better than the average in the country, which is closer to 60 cents on the dollar, so that drains over billions and billions of claims billions and billions of dollars out of our system and so very supportive of stronger enforcement of insurance companies, of managed care organizations, which I know have strong relationships with the state and enforcing parity in payment.

LETITIA JAMES: So, DOHMH and Health and Hospitals, you shoulder more of the burden of caring for uninsured patients and Medicaid reimbursement -- and Medicaid recipients. What are we doing to ensure that private hospitals are sharing the burden of caring for individuals who are suffering from mental illness?

DR. ASHWIN VASAN: I think you're raising a critical issue. H and H -- our partners at H and H provide about 20 percent of the healthcare -- physical healthcare in New York City. They provide 55 percent -- closer to 55 percent of the behavioral healthcare and addiction services in New York City. That's because the vast majority of those people, as you rightfully said, are on Medicaid and our private and academic systems systematically have shunted -- over decades, this is not a new problem, over decades of shunted these folks into our public safety net system, and we're very happy to care for them and provide them with the best services possible, but we can't do it without our academic partners, our nonprofit hospitals, our for-profit hospitals all rowing in the same direction and, you know, strong regulation would be a first step.

LETITIA JAMES: And commissioner, as you mentioned, New York state and federal law require that health insurance plans cover mental health and substance use disorder treatment, I mentioned this before, the same way that they cover all other medical treatment and our office

is deeply committed to investigating mental health parity and has -- we've entered into some agreements with multiple health plans to enforce compliance with these laws. Again, if there is any member of the public that needs to contact our office, they can fill out forms on our website to inform us -- inform us of the lack of parity with respect to insurance plans and/or medical facilities.

How is the city prepared to build out services and staffing to respond to the new 9-8-8 line, and what can we do to accelerate the rollout of crisis stabilization centers as was passed in the law in 2021?

DR. ASHWIN VASAN: Thanks for the question. We're very proud of the work that NYC Well is doing to not only give access to a range of mental health supports telephonically and digitally, it's really the best in the nation, and it's on that foundation we will build and implement 9-8-8. We're very excited to partner with our -- with the state and with the Office of Mental Health to resource that.

We're using the same contractor, Vibrant Health, which runs 9-8-8, which also runs

NYC Well. And so, I think we are going to be a model in the nation. The health department leads on that work, and we're -- we are better staffed, we are better prepared, and we have a lot more experience than most jurisdictions in this country to implement 9-8-8 and to be a leader in this.

Once we get some of the operational issues out of the way, over time our goal is to have a single hotline. But right now, I think we're still encouraging New Yorkers to call NYC Well to get services.

LETITIA JAMES: Last two questions, Commissioner. Beds were taken offline during COVID emergency suspension of regulations and they remain offline to this day. Is the city tracking beds in the system and urging facilities to put these beds back online so that they can treat individuals who are struggling with mental illness?

DR. ASHWIN VASAN: Yeah, you're raising a critical issue and it especially occurred in our private and academic hospital systems.

LETITIA JAMES: Yes.

DR. ASHWIN VASAN: As you know, that's

regulated by the state. We have no regulatory authority over city -- even hospitals in our city other than our public hospital system. But yes, absolutely. We're talking with our health system partners every day about how they can participate in our public health response to our psychiatric crisis or mental health crisis.

LETITIA JAMES: So, is it your position that within the Department of Health and Hospitals, all of those beds that were taken offline are back -- are now online?

DR. ASHWIN VASAN: That isn't my position and that isn't something I can attest to. I think efforts to get those beds back online would start with the regulatory body and that has to come from the State Health Department.

LETITIA JAMES: And lastly, we know that many more people with serious mental illness are in jails than in psychiatric centers. What is DOHMH doing to make sure that mental health is being provided on Rikers Island?

DR. ASHWIN VASAN: Right, so correctional health services is actually run out of our partners at New York City Health and

Hospitals and has been for -- since the federal settlements in I believe 2015 or before that, and so we partner closely with them, especially on reentry services, because we know that that -- the initial days and weeks after someone is released from jail are incredibly vulnerable periods in terms of a person's health. But in terms of providing care directly inside of Rikers Island, that's our colleagues at New York City Health and Hospitals.

LETITIA JAMES: And Commissioner, I do know that you have individuals who are reaching out -- outreach teams that are reaching out to individuals in the subway system, in our streets, individuals who are self-presenting. So, what are they -- are they taking them to emergency rooms or taking them -- what are they doing to address their conditions?

DR. ASHWIN VASAN: They're taking them to whatever -- a variety of destinations. Psychiatric emergency rooms and regular emergency rooms are just one possible destination if we identify an acute need. But so many of the people we encounter through our subway outreach program need a hot meal and need some clothes and

they need someone to talk to.

And it's exactly the kind of investments in social infrastructure that I mentioned in my testimony, support and connection centers, club houses, our connect programs, these are the first stops, the first ports of call. Crisis stabilization centers that you mentioned, these are -- should be the first ports of call. And we're finding increasing numbers of people willing to accept that referral and willing to accept transportation to one of those sites to start the process of getting their life back on track.

This is hard work. We've published the data. It's tens of thousands of engagements to build trust over time in order to get maybe a couple of thousand people off the subway and off the street. But they're staying off the streets because we keep coming back.

This is not an issue we're kicking down the -- kicking the can down the road on. We're staying and sticking with it and I'm very proud of the commitment of this administration in doing so.

LETITIA JAMES: And it's the state

regulatory body that determines when individuals actually get care, how long they're in the emergency room, and when hospitals are back online -- when beds are back online for mental health patients?

DR. ASHWIN VASAN: That's right. All hospitals in New York state, including those in New York City, are regulated by the state Department of Health.

LETITIA JAMES: Thank you.

GINA BULL: Can I -- one quick follow-up. Commissioner, you mentioned that the 9-8-8 response will be managed by the same contractor that handles NYC Well. We've heard from advocates that calls to that mobile crisis or NYC Well can be quite delayed and that they're still told to call 9-1-1 or bring family members to the emergency room for emergency issues. Will that change under the 9-8-8 response? Will that be -- will we be able to divert mental health emergencies from police response?

DR. ASHWIN VASAN: It's a great question and we're very proud of the city of our Be Heard program, our behavioral health -- non-police response behavioral health program, which

is currently accessed through 9-1-1. But over time we expect it to be accessed through 9-8-8 as well. And in the most recent executive budget, we are expanding that program to -- from its initial pilot in Northern Manhattan and Harlem, and so that's exactly the kind of non-police response -- mental health first crisis response that we plan to scale across the city, and we're in the process of doing just that.

GINA BULL: Thank you.

LETITIA JAMES: Thank you Commissioner.

DR. ASHWIN VASAN: Thank you.

LETITIA JAMES: We have received a response from the New York State Office of Mental Health, and I'll read it into the record.

As we all know, the last two years of the COVID pandemic have presented unprecedented challenges to the mental health of individuals and families across our state. The mission of the New York State Office of Mental Health is to promote the mental health of all New Yorkers with a particular focus on providing hope and recovery for adults with serious mental illness and children with serious emotional disturbances.

With an estimated 40 to 50 percent of

New Yorkers having a significant mental health impact from this pandemic, there is an increased need for timely and effective services that reach equally to all our communities.

The pandemic has also alerted us to the increased need for mental health prevention and wellness and the need to address any hesitancy about asking for help when needed.

During Kathy Hochul's tenure, a historic 577 million -- 17.2% -- increase has been invested for critically important community mental health program services and initiatives. This includes a historic and comprehensive series of investments to expand and strengthen children's services including school-based mental health services and resources, launching the country's first youth assertive community treatment teams, expanding the integration of mental health services into primary healthcare settings, expanding youth mental health first aid training, increasing rates for children's residential treatment facilities and a host of other investments for our youngest New Yorkers.

Furthermore, the governor recognized the need to invest in New York's comprehensive

crisis response system to establish intensive crisis stabilization centers across the state, adequately fund the launch of 9-8-8, the National Suicide Prevention and Behavioral Health Crisis Hotline, increase funding for inpatient psychiatric beds, establish more supportive housing opportunities for New Yorkers, and invest in and launch the SOS homeless outreach teams to reach thousands of New Yorkers who need stable housing and support services.

The governor has also invested in the backbone of the mental health system, its workforce with healthcare and mental health worker bonuses, a historic 5.4 percent COLA funding to recruit psychiatrists and nurses, launch a mental health wellness community workforce pilot, and other critical investments for the heroes who show up day in and day out.

This is just a start. The governor will continue to work with local, state, and federal partners to ensure that we continue the work that we have jointly embarked upon to transform New York's mental health system.

Respectfully, Dr. Anne Sullivan, Commissioner of the Office of Mental Health New

York State.

Next witness.

ABISOLE FATADE: I'd like to invite Harvey Rosenthal, Geoffrey Berman, and Sabina Kahn up to speak, please.

Welcome and thank you for your patience. Have you all been sworn in?

SABINA KAHN: Yes.

ABISOLE FATADE: Okay, thank you. And Harvey Rosenthal, please proceed when you're ready.

HARVEY ROSENTHAL: Good afternoon, Attorney General and your team. Thank you so much --

LETITIA JAMES: Afternoon. Thank you.

HARVEY ROSENTHAL: -- for weighing in on this issue and showing the kind of interest we've not seen from this department. I'm Harvey Rosenthal. I'm with the New York Association of Psychiatric Rehabilitation Services. We're a 40-year-old partnership of people with serious mental illness of the kind we're talking about today. People who otherwise would be incarcerated, hospitalized, homeless, suicidal, isolated or idle are in recovery now because of

the range of community services that we've been able to offer.

This is a personal story. I started my career as a mental patient in a hospital on Long Island for six weeks. Several years later, I was working in the state hospital in Albany, and we've created programs over the years to help -- with peers to help people get out and stay out of hospital.

I'm going to just say quickly that recovery is for everyone and that we should never count anyone out. We should look at the shared -- here's some passionate comments today. You heard from the Commissioner about relationship, meeting people where there are. (Indiscernible) say when you hear about the hard to serve, it's our responsibility to figure that out. It's not blaming the person.

The answers are ultimately in the community. I -- I'm not here to talk about more hospital beds. I think we know how to help people before, you know, to avoid admission and to get them out of hospital and we have a continuum of care. So, I would be concerned about a re-institutionalization and a focus on

more beds. I actually have real qualms about the IMD exclusion sort of waiver, because again, it allows Medicaid to build hospital beds, something we've moved away from I think for good reason.

We need to look at beyond beds and treatment. You heard from so many people, the social determinants of health are critical. We've run managed care programs in New York. We've worked with people that are multiply hospitalized, jail, prison, et cetera. They're not telling us they want hospital and medication. They want food, they want housing, they want, you know, social sort of connection. They need money. These are the things we ought to be really focused on.

This was a good budget, but it also was a mixed bag. We saw all that money that was put in the budget, but the governor and the legislature at some point started to conflate violence and mental illness, and next thing you know, we have a whole package of coercion.

We're against coercion. Coercion has not been proven to work. It's our responsibility to know how to engage people. We do know how to do that. We have programs in Westchester that

engage people that otherwise would be on court orders by peer support, relentless, you know, really person-centered approaches that never quit. We never quit.

A couple of things. Hospitals, so many people are in and out of hospitals. All the people in newspapers were in hospitals years, weeks before these tragedies happened. Hospital discharge plans are key, whether people are there longer, perhaps they need to be there longer, but people should leave with follow along support and housing.

There's Peer Bridgers that could follow them nine-month periods. There's a model that we've created with low-threshold housing, housing first (indiscernible) people even if they're using and even if they are not using medication, critical discharge planning.

We again have worked for years with people. We worked with a man, seven detoxes in one year. We provided peer support for a period of time, daily check-ins, seven detox to one. Medicaid spend was cut in half.

The recovery crisis continued we've heard about. All of that is really important

given the time, 9-8-8 really important. Crisis stabilization is important. But you know what? It's only one day. It's a one-day program. So it's really important to have the follow along crisis respite and other programs. We know how to do that. We're doing that in Buffalo, 28-day programs, 14-day.

Mental health alternatives to first responders are really critical. The cahoots model in Oregon, 30-year-old model, really shows that when mental health peers and EMTs go out rather than police, you get engagement and de-escalation, you avoid arrests, et cetera.

I want to talk a little bit about when -- you know, I don't know if this is your purview, but when -- we really have needed to stop solitary confinement in state prisons. The halt bill is doing that.

I'm told that the department of corrections is not -- does not look like it's going to implement the law the way it's intended, and any help you can do in that area. We're trying to ban solitary confinement and provide rehabilitative alternatives. The waiver that's supposed to come out will restart Medicaid 30

days before discharge. It's really important.

And finally, racism and inequity in people of color, people of color in New York City since 1999 have had 77 percent of (indiscernible). That's outrageous. That shows you we're unable to engage people voluntarily. People (indiscernible) why should that be that that we're forcing all these people of color into treatment? Why should it be that jails and prisons are filled with people of color with mental illnesses? This is a failure to engage and it's about changing a racist sort of system perhaps. But it's about hiring the right staff and the right administrators who look like and speak like the people that they're serving. But it's critical. I'll just stop there.

LETITIA JAMES: Thank you.

ABISOLE FATADE: Thank you. Geoffrey Berman, please proceed.

GEOFFREY BERMAN: Good afternoon.

LETITIA JAMES: Good afternoon.

GEOFFREY BERMAN: I'm a 25-year public defender and mental health specialist with the legal aid society. I am here to urge your office to advocate for increased access to community-

based mental health care and to support creating off ramps from the criminal legal system as an alternative to jail and prison.

Yes, the state is lacking inpatient treatment facilities, but this is actually a problem of mass incarceration and not offering sound solutions. One in five New Yorkers and approximately half of the roughly 40,000 people incarcerated throughout New York has a mental health condition.

Poor discharge planning and a lack of long-term resources such as housing, employment, and healthcare creates a revolving door of incarceration for many. This is a public health crisis that must be met with a public health solution.

A solution is the Treatment Not Jail Act, a transformative bill pending before our state legislature. Treatment Not Jail builds upon our existing and successful statutory drug court framework to mandate mental health courts throughout New York.

With these courts in place and funding of robust community programming options, which will prevent individuals from reaching a crisis

point, we can finally turn away from incarceration and impatient psychiatric care and reliance on that.

I encourage your office to expand your focus beyond the well-documented lack of inpatient psychiatric beds and to get to the heart of what is really happening. Fearmongering around public safety has perpetuated a lie that incarceration makes our community safer when in fact, it makes people more likely to reoffend.

That same narrative often portrays people with mental health conditions as dangerous. However, studies show that a person with a mental health condition is 10 times more likely to be the victim of a violent act than the perpetrator of a violent act as well as additionally that a person who is charged with a violent offense or has previously been convicted of a violent offense is just as likely to be successful in a diversion court as somebody charged with a nonviolent offense.

Incarceration is traumatizing and destabilizing. People languish inside jails and prisons with inadequate mental health treatment and medical care while exposed to trauma,

violence, and rampant drug use. They emerge into shelters or the streets and are expected to obtain housing, treatment, jobs, and benefits while navigating the adverse collateral consequences of their criminal conviction.

This is a recipe for increased substance use, a recipe for untreated mental health conditions, psychiatric admissions and recidivism. Many of the people experiencing this revolving door are eligible for community-based mental health services but cannot access them because the state has failed to fund them. Instead, we see investment in incarceration at the astronomical cost of $556,000 per person per year at Rikers Island.

In 2019, the 57 counties outside of New York City collectively spent more than $1.3 billion to staff and run their jails. The Treatment Not Jail act will improve public safety by expanding the state's drug court statute passed by Republicans during the budget process in 2009.

Currently, a small fraction of nonviolent charges are eligible for judicial diversion. Likewise, people with serious mental

illness, intellectual or developmental disabilities are routinely rejected in diversion courts because substance use is not their primary focus.

Additionally, access to existing ad hoc mental health courts throughout the state of New York is unevenly and minimally applied due to our prosecutor's gatekeeping power. Without legislating mental health courts, our judges lack the power to admit a vulnerable and deserving person into a treatment court that will change the trajectory of that person's life.

We urge you to expand your vision of what successful mental healthcare looks like and support investing in off ramps from the criminal legal system, including community-based treatment and implementation of the Treatment Not Jail Act. Thank you.

LETITIA JAMES: Thank you.

SABINA KAHN: Good afternoon.

LETITIA JAMES: Good afternoon.

SABINA KHAN: Thank you for the opportunity to address the New York State Office of the Attorney General. My name is Sabina Khan. I am a staff attorney at Disability Rights New

York, the New York State protection and advocacy system for people with disabilities.

As background, DRNY provides free legal advocacy for New Yorkers with disabilities, including people with serious mental illness seeking access to mental health services and supports.

As part of its role as New York's protection and advocacy, DRNY has an interest in ensuring that people with disabilities receive the support they need to live independently in their communities and have autonomy over their life choices.

It is correct that there is a mental health crisis in New York state. DRNY regularly hears as much from our clients and the communities we serve, including lower income children and families, incarcerated and formerly incarcerated people with mental illness, and people with disabilities who are unhoused or face housing instability, all of whom are being deprived of legally mandated mental health care.

When addressing this crisis, however, it is critical that the right questions are asked. The notice for this hearing placed

particular attention on the difficulties that New Yorkers have in accessing inpatient services and noted the impact of COVID-19 on the mental health service system.

We urge you to consider instead two different ways of framing New York's mental health crisis. First, focus needs to be placed on the statewide challenges that people with mental illness have in obtaining community-based mental health services.

While we agree that inpatient care should be available to New Yorkers who need it, far too many people are forced to seek this level of care after being denied access to community supports.

We see the same crisis in the delivery of services to our children. Children who are not getting the help they need at home and in school are ending up in in-state and out-of-state facilities far away from their families. Adults and children are forced to seek out higher levels of care or are forced into them simply because the community-based services that they need or have long needed are unavailable.

Counseling, intensive care management,

community-based mental health crisis services, peer support services, psychiatrists, psychologists, and more are -- all remain out of reach for far too many people who need them.

New Yorkers have a federal right to receive services in the most integrated settings appropriate to their needs, and adults and children should never feel that when it comes to their mental healthcare -- when it comes to their mental healthcare needs, and yes, even their intensive mental health service needs, that they have the option of either inpatient hospitalization or having nothing at all.

Investing in inpatient beds can never address the longstanding failures to ensure that there is a robust and effective system for community-based mental health care in all parts of the state.

Finally, we urge that all that participate today recognize that New York's -- New York state's mental health crisis is not new, nor was it created as a result of the COVID-19 pandemic. No one can deny the horrific impacts of the COVID -- that COVID-19 has had on all New Yorkers, particularly those from the BIPOC

communities, and the pandemic has had a disproportionately negative impact on people with disabilities.

Even though people with disabilities and chronic conditions were at particularly high risk, pandemic -- with devastating impact. But it would be misleading to suggest that the current mental health crisis in the state is purely or even principally the result of the pandemic.

Being honest about the causes of the crisis means looking at the state's failures to invest in its communities. The lack of community-based mental health care for children and their families, adults, older New Yorkers predates the pandemic.

The state's reliance on segregated settings to address the mental health service needs of all adults and children in crisis predates the pandemic. The state's failure to ensure that incarcerated people with disabilities receive the care and services they need and that people with disabilities are diverted from incarceration wherever possible predates the pandemic, and the use of deadly responses such as

law enforcement as a substitute for true mental health crisis services predates the pandemic.

So, we urge you to consider how long-standing practices have led to these problems and how these problems are driving New York State's mental health crisis. Thank you for the opportunity to provide testimony and for considering my remarks.

LETITIA JAMES: Thank you. At the outset, I gave a historical perspective about the underfunding of community-based organizations and deinstitutionalization, and that's how we got here and there -- and I don't think this is an either/or proposition. Obviously, there is a need for some hospitalization and definitely a need for community-based organization, but in the absence of funding for community-based organizations and when you take offline psychiatric beds, what do you have? You have individuals who are in the criminal justice system or on our streets.

And so, the framing of this is that you're absolutely right, the framing should be on community-based organizations, but also all of those beds that were taken offline should be put

back online to specifically address individuals with acute issues -- with acute problems. Do we all agree with that? Okay. So, what community-based organizations are most effective at preventing hospitalization and incarceration? What are the models that are out there that are evidence-based?

HARVEY ROSENTHAL: Well, I mentioned earlier about this (indiscernible) program in Westchester County. It's a model that's -- it's a peer-based model that sends people out again and again to train stations -- I mean bus stations and people who are closeted in their homes, people, you know, who are leaving prison and jail, the same people who would otherwise be on Kendra's Law and they engage 80 percent of the unengageable, so I think that's a model that we really ought to be looking at.

The Peer Bridger model, we created that in '94. It helps people leave and stay out of state and local hospitals. Again, with the intensive peer support, not -- I think that's how you're going to keep people from going back to hospital, a good discharge plan with a follow-along peer and better housing. I think the low

demand housing is really critical. Otherwise, people -- you know, you're not able to engage people in a correct way. So, I would say housing, peer support, peer outreach and engagement. I think these crisis programs are going to be really important.

I would rather see us invest in getting (indiscernible) you got 600 beds, you're going to put them online, you got the buildings there, you can put them up. Okay. But that ultimately -- we need much more money going into these -- some of these programs can come up rather quick, even in the Biden budget, the (indiscernible) budget, there is some money for crisis services.

So, if we could funnel all that money and get it going, I think that's critical. I would hate to see us rely on hospitals simply because we can't get community services up fast enough.

LETITIA JAMES: So, in the budget Governor Hochul announced funding to develop -- I believe it was in the budget -- 10,000 units of supportive housing over five years as well as 500 additional scatter site supportive housing beds to transition those in crisis from the street to

stable housing. I think I know the answer to the question. Is this adequate?

HARVEY ROSENTHAL: No, but it's come a long way. I mean, I think the governor did a great thing here. I think New York has 40,000 beds before this allocation, so we're ahead of the country in many ways but the need has far outstripped what we have.

LETITIA JAMES: But it's been years of underfunding --

HARVEY ROSENTHAL: Absolutely.

LETITIA JAMES: -- and/or years of neglect, and the Treatment Not Jails bill was not passed in this legislative session, correct, Mr. Berman. What is the likelihood --

GEOFFREY BERMAN: (Indiscernible).

LETITIA JAMES: I'm sorry?

GEOFFREY BERMAN: It was not even (indiscernible) for a vote.

LETITIA JAMES: In both houses?

GEOFFREY BERMAN: Both houses.

LETITIA JAMES: And in that bill, that would provide for housing and other support services that individuals struggling with mental illness need.

GEOFFREY BERMAN: That's right. That's right. You know --

LETITIA JAMES: Was there a hearing on the bill?

GEOFFREY BERMAN: There have been -- there was a budget hearing where there was testimony about the Treatment Not Jail act. I mean, I -- as far as I know that was one of the hearings that took place.

You know, housing, the different types of community programs that he's speaking about are just so critical. I can't say enough about the impact that an ACT team, that an IMT, intensive mobile treatment team, that a PROS program, personal recovery oriented services program, that supportive housing programs has on our clients.

Simply putting somebody in the hospital for 30 days to be psychiatrically hospitalized and then discharged to a shelter and expected to make an appointment halfway across town with a 28-day supply of medication is completely inadequate.

The way to deal with this mental health crisis for people who become entrenched in the

criminal legal system is to take all of this money that is being put into jails and divert it into community programming.

While we acknowledge the importance of inpatient settings, acute services and crisis services, we support deinstitutionalization and are seeking a massive statewide expansion of community-based mental health services including for supportive housing for these intensive mental health treatment programs, which by the way are proven to decrease psychiatric hospitalizations.

LETITIA JAMES: And I'm not sure who mentioned it. Someone mentioned an Oregon model. Can someone --

HARVEY ROSENTHAL: Yes, I did.

LETITIA JAMES: -- Tell me more about the Oregon model?

HARVEY ROSENTHAL: Yeah, CAHOOTS, crisis assistance out on the street, something of that nature, is a model that instead of police, it sends peers, mental health counselors and peers and emergency medical technicians. It is possible that Daniel Prude would be alive today if instead of a police sort of restraint he got a medical personnel and a peer who might have been

able to deescalate the situation.

I also want to mention core services, which is another home and community-based services the OMH is rolling out. The beauty of these is they go to the people. We can't wait in our offices for people who don't show up and blame them.

The core services are going to dispatch, you know, peer counselors and others into the community in a big way. We're really excited about that.

LETITIA JAMES: And mental health courts, how many are there in the city, throughout the state as far as you know? I'm only familiar with two in the city.

GEOFFREY BERMAN: Sure. The number of people served by mental health treatment courts statewide are abysmal and only about half of New York's counties have such a court. The court system operates as of 2020 -- this is through the New York State Judiciary Court -- in 2020, the court system operates 30 mental health courts with five more in the planning stage and this benefited 140 participants for specialized services.

LETITIA JAMES: 140?

GEOFFREY BERMAN: That is pursuant to the 2020 New York State --

LETITIA JAMES: Statewide?

GEOFFREY BERMAN: -- judiciary report. And you know, one thing that's happening and it's very important to point out is the only law that pertains that gives a judge discretion to order diversion is the drug court statute, and that came out of the 2009 Drug Law Reform and -- it's called judicial diversion.

But what we see happening throughout the stage is that when somebody is otherwise eligible for drug court but for the fact that they have a serious mental health condition, judges in these courts are saying we don't have the ability to support this population and they kick it back over to prosecutors who then have to make a decision about whether to divert that individual to an ad hoc mental health court.

And unfortunately as we're seeing, not enough people are being diverted into mental health courts. And what is happening is that this population is then incarcerated in state prison or incarcerated at Rikers Island or

incarcerated in a local jail. And when they get out of prison or when they get out of jail, they don't have anything and they're expected to survive. And this is a recipe for inpatient psychiatric hospitalization and a recipe for recidivism.

LETITIA JAMES: And are they refer -- is there a community-based organization that is tied to or connected to these mental health court -- treatment courts?

GEOFFREY BERMAN: In New York city for example, there are -- the mental health courts and the drug courts are contracted with various agencies such as EAC that, you know, these agencies are contracted with the courts and work with the courts to put together treatment plans, to do the clinical evaluation and to make a recommendation. And then -- and then the prosecutor and the defense attorney would then, you know, state their position and their hope for what they want to see happen, and it's up to the judge ultimately, at least in a drug court, to divert somebody. With respect to a mental health court, prosecutors are holding all the cards.

LETITIA JAMES: Thank you for your

testimony. I appreciate it. Thank you, all.

HARVEY ROSENTHAL: Thank you.

ABISOLE FATADE: I'd now like to invite Burrough President Mark Levine to speak.

LETITIA JAMES: So, Mr. Burrough President, I hope you're not offended. They told me that I'm an hour behind. So, I'm not going to ask you any questions.

MARK LEVINE: I'm off the hook. It is wonderful to see you, Attorney General, and I want to tell you how grateful I am that you are focusing the resources of your office on this topic.

As far as I know, you're the first attorney general ever to hold such a hearing on the topic of mental health.

LETITIA JAMES: Well, I'm sort of different.

MARK LEVINE: Okay, well in my book, you're the first. You can let your predecessor yell at me if that's not true.

I want to talk about four policy priorities to deal with the kinds of chronic mental health crisis that is in the news that many of your other panelists have spoken about

and that demands our attention.

First, improving the way that we respond to people who are in crisis, improving expanding the teams we send out. Secondly, creating more alternatives to care other than an emergency room. We need intermediate options. Third, reversing the hemorrhaging of inpatient psychiatric beds in hospitals. And forth, expanding the number of supportive housing beds.

I'll start out with the crisis response. Traditionally if a family needed help they would call 9-1-1 and police officers would come. In the last seven years in New York City, 19 people have been killed in such interactions.

We need an alternative, and there's a pilot now, Be Heard, which I think was referenced earlier which is in place in precincts in northern Manhattan, so I know it well. It allows the 9-1-1 dispatcher to elect to send out not police officers but a team of two EMTs and a social worker.

This avoids the risk of violent confrontation but it's also had some other important successes in this pilot phase. The patient, the person in crisis, is less likely to

need to be sent for inpatient hospital care after a Be Heard visit because you have professionals who are good at calming the situation, alleviating the crisis, and that's really a win if you can help someone achieve stability without needing hospital care. It's only in a few precincts. Even those precincts where it's active, it's not operating 24/7 and so we want to expand it citywide and we want it to be around the clock. We also want to expand the system of crisis response teams that is now dispatched when you call 8-8-8 NYC Well. The wait can be several hours even though it's considered an emergency response. And they're only operating between 8 a.m. and 8 p.m.

Secondly, an alternative to ERs, emergency rooms are actually not good places for someone in mental health crisis. They're often chaotic. They're loud, buzzing sounds and flashing lights. They can really make a bad situation worse.

That's where the option of something like a medical respite bed comes in, a place you can go for as many as a few weeks where you can get light touch treatment, often by peers. It

can be just what a patient needs. There are 21 respite beds in Manhattan for people with psychiatric challenges. We should start by at least doubling that and expanding other innovative models that you've heard from -- heard about today such as the living room model which allows for longer stays with professional staff. Excuse me, not longer stays, stays of up to 72 hours with professional staff. Again, an alternative to going to the ER with all the problems.

Next, there's the hemorrhaging of inpatient psychiatric beds. Manhattan lost about 450 inpatient psychiatric beds in the decade preceding the pandemic, and then during the pandemic the rules that govern this so-called certificate of need structure were suspended for emergency reasons and we lost many more beds.

We don't even know the exact number because some of the regulatory rules were suspended. We need to bring that regime back into place so that hospitals are held accountable for these decisions. We also clearly need to fix Medicaid funding. The finances are tough for hospitals, much tougher than they are for

traditional medical purposes, and we have to fix that.

The governor, as was mentioned, made progress on that in the budget. Much more work to do. We also need innovative plans like allowing families to care for their loved ones who have mental health needs in their home.

Medicaid will provide families funding to care for patients who have physical ailments under certain conditions. Let's pilot that kind of work for families taking care of people with mental health challenges to avoid them needing to go into the hospital.

Finally, supportive housing. This topic was just discussed. The estimate in New York City is in need of 86,000 supportive housing units. We have 32,000 today. Add up all the units that are in the pipeline from the state and the city, that will get us to a little over 50,000, still leaving a gap of over 30,000. So, while we have made progress, we have so much more work to do to meet the needs for all New Yorkers who need supportive housing.

So, there I've laid out four major categories. I appreciate you letting me go a

little over time and I'm grateful for the chance to testify. Again, thank you Attorney General for focusing on this critical issue and thank you for not asking me any hard follow-up questions.

LETITIA JAMES: Thank you, Mr. Burrough President. Thank you for your recommendations. I really appreciate it.

MARK LEVINE: Okay, thank you.

LETITIA JAMES: Focusing on those four issues.

ABISOLE FATADE: I'd like to invite Councilman Eric Bottcher.

LETITIA JAMES: Council member Bottcher, they tell me I'm behind schedule, so I'm not going to ask you any questions.

ERIC BOTTCHER: I heard you say that to the Burrough President.

LETITIA JAMES: I'm going to extend it to you, because --

ERIC BOTTCHER: Thank you.

LETITIA JAMES: -- I'm way behind.

ERIC BOTTCHER: Thank you very much.

LETITIA JAMES: Thank you, Council member.

ERIC BOTTCHER: I want to begin,

Attorney General James, for thanking you for holding this hearing on access to mental healthcare for New Yorkers with serious mental illness.

My name is Eric Bottcher. I represent council District 3 in the city council. I'm also a member of the Committee on Mental Health, Disability and Addictions. The issue of mental health is personal to me.

When I was in high school following a series of suicide attempts, I spent a month at a mental health hospital in upstate New York. The treatment that I received at Four Winds Hospital saved my life.

Unfortunately, that is treatment that is unavailable to so many Americans, particularly if you are poor or a person of color, which is one reason why I've been focusing on the need for more access to inpatient residential programs for mental healthcare and why I've also been speaking out about the federal rule that has been blocking access to these services for so many, the so-called IMD Rule, Institutions of Mental Diseases Rule.

With the stroke of a pen, a president,

Lyndon Johnson, expanded healthcare coverage for tens of millions of Americans when he signed the Social Security Amendments of 1965. But buried within this landmark legislation was a rule that sealed the fate of millions of people living with serious mental illness, relegating many to live in jails, prisons, shelters, or on the streets.

The so-called IMD Rule prohibits Medicaid payments to psychiatric hospitals and other residential treatment facilities that have more than 16 beds and that treat patients age 21 to 64.

If the goal of the IMD Rule was to accelerate the closure of long-term care facilities and psychiatric beds in the United States, it was a spectacular success. We now have 96.5 percent fewer state hospital beds than we did at our country's peak in the 1950s.

The actual intention was to shift mental health services to community-based outpatient treatment programs. While many quality outpatient programs exist today, the reality is that for millions of the poorest Americans, this translated into no treatment at all.

People living with serious mental illness are not guaranteed the help they need, resulting in needless suffering and harm. This is one reason why half the population of Rikers Island has received ongoing services for mental illness during their stay.

The IMD Rule is preventing residential treatment facilities from opening in New York City today. One of these facilities is Hope House in Crotona Park, a project of the Greenberger Center for Social and Criminal Justice. Hope House is an alternative to incarceration for people with serious mental illness or substance use disorders. Hope House first received city council funding in 2015, yet seven years later, it is yet to open.

Efforts to build, license, and open the facility have been met with roadblocks at nearly every turn, especially the ineligibility for Medicaid reimbursement due to the IMD Rule. While states can apply for a waiver to cover short-term stays in psychiatric hospitals, federal lawmakers have had -- had an opportunity to fix this problem permanently. Representative Carolyn Maloney has introduced a bill to repeal

this rule, the Michelle Go Act, named after a woman tragically killed in January in my district by a 61-year-old man who had shown previous signs of serious mental illness what was not provided with adequate mental health care.

This bill would amend the Social Security Act to allow facilities with more than 16 beds to receive Medicaid funds and require them to meet nationally recognized, evidence-based standards for mental health and substance use disorder programs.

It already has the support of groups like the American Society of Addiction Medicine, the National Alliance on Mental Illness, The Partnership for New York City and Treatment Advocacy Center.

It is unconscionable that federal regulations and bureaucratic red tape are getting in the way of getting people with serious mental illness into settings where they can receive proper treatment.

We can no longer accept a world where people with mental illness are funneled into jails, the shelter system, or left to die on the street. The IMD Rule should be repealed to give

millions of Americans the opportunity for a better life. Thank you very much.

LETITIA JAMES: Council member, do you know whether or not Senator Schumer is supportive of this IMD exclusion repeal?

ERIC BOTTCHER: I heard you ask that of Commissioner Vasan, and I do not know, but it's something we should all work on after this hearing.

LETITIA JAMES: Thank you. I appreciate you. Thank you for your testimony.

ERIC BOTTCHER: Thank you very much.

LETITIA JAMES: Great to see you.

ERIC BOTTCHER: Likewise.

ABISOLE FATADE: I'd now like to call on Jed Wolkenbreit, Leonidas Bell, and Alison Burke. Please come testify. Thank you for your patience and have you all been sworn in?

ALISON BURKE: Yes.

ABISOLE FATADE: Okay, thank you. Please proceed when you're ready, thank you.

JED WOLKENBREIT: Madam Attorney General, thank you for this opportunity to testify today. My name is Jed Wolkenbreit. I'm counsel to the New York State Conference of Local

Mental Hygiene Directors, namely the conference, and given the time constraint we've submitted detailed written testimony. I'm just going to summarize some of it, if I may.

The conference itself consists of the directors of community services. Those are the commissioners of mental health of the City of New York and the 57 other counties.

We were created by statute under the mental hygiene law and as such, the DCS's have the statutory responsibility for the oversight of mental hygiene services to both adults and children residing in their counties.

DCS's also have linkages to various other health and social service systems in their jurisdictions and have a unique view therefore of the needs and problems facing the people they serve. It is the DCS's essentially who have to pick up the pieces when others fail to appreciate or do not care about the implications of their actions and we now face a crisis because of those actions.

Others have thoroughly documented the effects of the haphazard deinstitutionalization of patients from state mental health hospitals,

federal cutbacks, the closure of over 93,000 state inpatient beds over time, Article 28 Hospital Consolidations, and of course the implications of the COVID-19 pandemic measures have all contributed to the bed crisis, of course.

DCS's know about these pressures on the providers of services to individuals who are suffering from serious mental illness and people -- especially those who need somewhat of a more intensive level of care. We also recognize the benefits and importance of treating people with mental health disabilities in least restrictive settings, but we also realize that on the road to recovery, many from time to time may need a period of hospitalization to help them handle some of the potholes that they may experience along that road.

With fewer state PC beds and Article 28 beds continuing to close, both temporarily and sometimes permanently, local communities need help in making sure that these patients receive the help they need, because most crisis evaluations occur in Article 28 emergency room bed crisis units.

The demand for these evaluations has increased substantially. ED stays have increased because there's no beds to put people in. And remember, we're talking about people in crisis. The closures of course have contributed to making jails and prisons a primary source of mental health treatment in some communities and many communities, as you've heard, are facing substantial challenges in finding psych resources for young children.

We have several recommendations, actually three. One, that if hospitals and/or state psychiatric centers are allowed to continue to take beds offline or even to temporarily close them, then any monetary savings should be returned to the communities and reinvested back into communities to provide for that safety net. These investments are critical to our providers left at the bottom of that safety net.

Secondly, DOH, the Department of Health, should have a daily reporting system, much like you mentioned before in which hospital beds can be accessed by the counties, something that would show bed capacity including any beds that have been taken offline. Community-based

providers are actually required to do such reporting, and there's no reason that the state should not be doing the same thing.

And thirdly and finally, OMH PC admission criteria and referral processes via the health commerce system should be reassessed for a smoother system transition from state -- from hospital beds -- Article 28 Hospital inpatient to state PCs. There's a 14-day rule that people have to be in an Article 28 facility for 28 -- for 14 days before they can gain access to a state bed. And that system is -- there was a pilot system that OMH did a number of years ago --

LETITIA JAMES: That's a state rule?

JED WOLKENBREIT: Yeah, it is. And the pilot has revealed that it's time to update this system. So, thank you again for the opportunity to provide comments today, and if you want to, I'll be happy to ask any -- answer any questions.

ABISOLE FATADE: Leonidas Bell, please proceed.

LEONIDAS BELL: Thank you. I want to thank the Attorney General and their -- her staff for holding this hearing today. My name is Leon

Bell, Leonidas Bell. I'm with the New York State Nurses Association. I'm the policy director. And I think -- I'm not going to go into a lot of detail about, you know, the erosion of inpatient as across the state and a lot of the capacity, but I do want to spend a few minutes talking about -- the time that I have talking about sort of the why, you know, the reasons behind some of these erosions of beds.

And it's clear, first of all, that COVID has exacerbated that problem. A lot of hospitals have taken advantage -- to be very blunt have taken advantage of the COVID situation. They've temporarily, quote -- air quotes for the record -- closed beds. And they either have no intention of reopening them or they're dragging their feet on doing it. And that's hundreds of beds on top of the beds that have been permanently eliminated.

I think the why for this erosion, particularly when it comes to Article 28 hospitals, has to do -- it's a simple matter of following the money. If you have -- you know, according to research we've done, we've submitted a report which I believe the -- your staff has

received that. It's about a year and a half old at this point, but according to our review of ICR data, which is data reported to the state Department of Health for billing and reimbursement and tracking purposes by hospitals, an average psych bed generates 88,000 a year in revenue. An average bed including the psych beds, total average bed, is 1.6 million. So when you look at a 20-to-1 or a 10-to-1 or a 15-to-1 ratio between what a hospital can make on offering inpatient psychiatric services versus hip replacements or cervical -- you know whatever, you know, fill in the blank, there's a whole slew of procedures that are much more profitable, it's clearly understandable why these hospitals are shedding their beds, particularly the large academic medical centers and they're increasingly consolidated networks that are acting more and more like for-profit hospital systems.

When you look at their pay structures and other factors, it's pretty clear that they are acting purely in pursuit of revenue and generating higher profits.

LETITIA JAMES: Somehow this reminds me

of the whole nursing home --

LEONIDAS BELL: Yes, it does, indeed.

LETITIA JAMES: -- debacle.

LEONIDAS BELL: And the one thing, though, that's slightly different from the nursing home context is the fact that due to various idiosyncrasies of New York's legal history, we don't have for-profit hospitals operating in the state of New York. We have for-profit, you know, medical providers of all sorts, including nursing homes, but the hospital system is -- except for a few grandfathered hospitals that, you know, were formed before 19 -- 1805 or you know, I'm making up the date, it's basically not for profit, which I think gives a lot of leverage to not only the state of New York but also to your office as the attorney general in terms of enforcing let's call it a civic obligation to provide services.

They may not want to because they don't generate as much money as others, but I believe that there is legal basis for action that could force or at least strongly encourage these hospitals to, you know, maintain these services and act, you know, as non-profits for the common

good, which is what they're supposed to be doing from a legal perspective anyway.

LETITIA JAMES: We're examining our options.

LEONIDAS BELL: So I apologize, I went a little bit longer. I would like to just say -- just to wrap up, I think, you know, we've made mention about the need to increase Medicaid reimbursement rates, but you need to consider in that increasing Medicaid reimbursement rates when we're talking about such a wide range of potential income revenues or income streams, you know, you could double the Medicaid reimbursement rate for inpatient care. It would still only be 200,000 per year or 150,000 per year versus 1.6 million per year.

LETITIA JAMES: Right.

LEONIDAS BELL: So, you have to keep that in mind, which is why I think the -- you know, it's great to increase the rates but it's not going to be enough to encourage or give an incentive to hospitals and other private providers to provide these services.

LETITIA JAMES: You would -- you would prefer as opposed to the carrot the stick

approach.

LEONIDAS BELL: I think the stick approaches is needed. You know, another potential stick is in terms of this sort of Whack-A-Mole that's going on with the temporary closures, again using air quotes for the record. You know, the state and I believe your office could have a role in basically ordering those hospitals to restore -- reopen all the units.

We are not at this point in a COVID crisis situation in terms of hospital capacity and there's really no reason that those units have not been restored to the psychiatric purposes with the understanding that down the road if there's a resurgence of the virus, we could, you know, repurpose them once again just like we did before.

I think another thing to look at is tightening state oversight --

LETITIA JAMES: Well, they can issue another waiver.

LENOIDAS BELL: Yeah. Another thing is to look at, you know, we have -- New York has a pretty stringent compared to other states CON, certificate of need process. Unfortunately it's

increasingly been implemented by the state in sort of a one-way direction which is to close units. So, they're very flexible about giving CON approval to close. They're -- the CON process has become more of a break on opening new units. I think it's time to look at that again and consider, you know, using the CON process which is pretty robust and allows the state to impose, for example, conditions on approving a new facility.

So, if you want to open up a new spinal surgical center that's going to generate the 1.6 million per bed that I was referencing earlier, that could be predicated on a conditional approval that says and you have to maintain X number of less profitable inpatient psychiatric beds, right?

So, that -- there's nothing stopping the state from doing that right now. And it's -- sometimes it's frustrating that -- to see the degree to which they don't exercise any power through that CON process.

Finally, there's legislation that's been talked about and I think it's something that given the crisis with mental health we should

implement a moratorium on closures of psych services, not just inpatient beds but psych services in the community and put them through a more rigorous process to show that there's an actual, you know, real basis for any sort of application to close.

And I think if the state took some of these more direct approaches, it would go a long way toward addressing this steady erosion over the last two decades in our inpatient capacity as well as the general systemic capacity.

I apologize profusely for going way too long.

LETITIA JAMES: That's okay. I caused it. Please proceed, Ms. Burke. Thank you.

ALISON BURKE: Good afternoon. Thanks very much for holding this hearing.

LETITIA JAMES: Thank you.

ALISON BURKE: My name is Alison Burke. I'm a vice -- you can't hear me. I'm sorry. No one has ever said that to me before. My name is Alison Burke. I'm vice president at the Greater New York Hospital Association. I am going to absolutely try my best to stay within the time frame.

You've really heard I think from everybody today and I was listening in the other room for a good portion of this afternoon's hearing. You've heard about really a lot of problems with this system. Our hospitals are a piece of the system and provide a wide range of services and inpatient hospitalization being one of them. Clearly -- we've heard it from today's -- this panel and others prior, it was a great year investment wise. We've been advocating very strongly for investment and reinvestment of money into the mental health system. This budget was profoundly welcomed by I think all provider categories.

COVID-19 created really significant challenges. We are in still a very -- while infection rates are down and hospitals are operating more regularly or routinely, we really have got a workforce crisis, and that is only made worse by the effects COVID has had on so many people in the community.

We're going to continue really to advocate for wise investments and reinvestments of money into the behavioral health system. Some of it is going directed specifically for the

workforce issues because we can't have any of these services if we don't have the workforce. So, there's some cost of living increases that we were very happy to have and also some loan repayments for psychiatric providers, nurse practitioners and physicians that are very welcome.

And I will say too, and you've heard a little bit about how the system has been evolving, and you've heard from others about wanting people with behavioral health issues to really remain in the community. We want them to not be institutionalized.

Now, we know there's always going to be a need for hospital beds and our members are committed to keeping those beds, and hopefully these investments we can build upon and certainly the state has heard from the provider community that continued investment is needed. It was a step in the right direction, but obviously much more is needed.

LETITIA JAMES: So, Ms. Burke, as far as you know, do you track how many offline beds are back online, psychiatric beds?

ALISON BURKE: So, I do not personally

track that, but we have field offices and the central office in Albany, the Office of Mental Health, has been having those conversations and there was a communication -- I have to apologize, I don't remember when it was, but it was from all of these state agencies, DOH, OMH, and Oasis saying when the infection rates were going down that people really needed to get their services -- all services, it wasn't just mental health psychiatric beds but all services back to their intended, certified purpose and all of our members have been doing that to the extent they can.

The challenging thing about mental health beds when they were converted for medical purposes in response to COVID, they had to be redesigned and medical equipment and ligature risks and looping hazards need to be all undone again.

So, in large part, most that I'm aware of, and I do check the pulse with our members, are getting them back in service for mental health purposes.

LETITIA JAMES: And Ms. Burke, you heard testimony about parity or lack thereof

between public versus private? What are your thoughts?

ALISON BURKE: Well, we very much support parity and reimbursement, and I think what New York did in the budget this year in making investments really does move the Medicaid dollars closer, not yet there, but closer to covering the cost of care.

LETITIA JAMES: Well, specifically as it relates to parity, that HHC, Health and Hospitals carries the burden whereas privates are not doing their fair share with respect to treating individuals who are struggling with mental illness, has there been any tracking of that?

ALISON BURKE: We have a number of members -- H&H is one of our members as well. We have a number of members across the state that operate significant numbers of inpatient psychiatric beds. Are there communities that probably need more or one provider is carrying a little more of the burden, absolutely.

LETITIA JAMES: Thank you. And I want to -- Mr. Bell, I want to thank (indiscernible) for their white paper on this issue and raising

this alarm about COVID closure -- COVID closure for psych beds early, and they brought this to my attention when I visited a number of facilities -- hospitals during a couple of events during the COVID period and then thereafter. So, I want to -- really want to thank (indiscernible) specifically for all that they are doing.

How should the state measure need for beds without relying on hospitals and self-reporting of capacities?

LEONIDAS BELL: Is that addressed to me?

LETITIA JAMES: Either or -- either/or.

JED WOLKENBREIT: Well, there -- I mean as of right now with community services we have to report to OMH and OMH keeps track of that. DOH could certainly do -- or DOH keeps track of that. That could certainly do the same thing with all of the hospital beds. The systems really exist already.

LETITIA JAMES: Yeah.

LEONIDAS BELL: Yeah, I think that there's several issues around that. First of all, OMH for example does track licensed beds and they issue a monthly report, which you know, I

looked at last night before coming to today's hearing. But it only tracks licensed beds. It doesn't track actually staffed beds or operating beds. So, one of the issues is that there tends to be overstatement of the number of beds that are actually out there, especially in the Article 28 hospital setting, because you know, a hospital may have 40 beds listed but they're actually only really staffing it at 20.

So, it's not exactly clear. The other thing is there are sort of generally accepted standards. You know, OECD average is used as for example 68 beds per 100,000 people. There's some other studies out there that have a slightly lower range, that it's 40 to 60 beds per 100,000 people.

By any of those criteria, we're not -- we don't have the bed capacity that we need. And again, I think the issue becomes what is the state going to do to make sure that we have that?

Because the market system, you know, so to speak has not -- has not stepped up. You know, the private hospitals have not stepped up. They're shedding these services because they don't make money on them.

So, it -- you know, I think there need to be standards set and we need to really carefully oversee and implement, you know, the provision of these psychiatric inpatient services as well as the whole range of mental healthcare services.

LETITIA JAMES: And Mr. Bell, are you also seeing workforce challenges?

LEONIDAS BELL: We are, you know, and it's no secret, you know, there's -- we haven't invested in our workforce and now, you know, we've come to the table with a -- you know 5.8 percent for the, you know --

LETITIA JAMES: COLA.

LEONIDAS BELL: -- you know, the COLA, and we've -- you know, the governor has set -- and this is great, set a goal of increasing the healthcare workforce by 20 percent over the next five years. You know, that's great, but you know we have a lot of catching up to do because we've been starving the system, as many have commented, throughout today's hearing for decades, and now, you know, it's time to pay the piper in some instance.

JED WOLKENBREIT: Just one other

thought. Many of these problems end up coming back to the local level, of course, and as the state cuts back and they do things like Kendra's Law, for example, when they created assisted outpatient treatment, that really falls back on the counties. There's really no state support for that kind of treatment. It's all done on the county level.

So, the other thing that I would ask that would be aware of the fact is that if other kinds of services or other kinds of things are going to be done, we have to remember that the counties can't afford to cover all of these things on their own and --

LETITIA JAMES: So, that goes back to your recommendation. Your position is Kendra's Law is an unfunded mandate --

JED WOLKENBREIT: Exactly.

LETITIA JAMES: -- and any savings as a result of the closing of these beds should be reinvested in local communities.

JED WOLKENBREIT: Exactly. Exactly.

LETITIA JAMES: Thank you all.

JED WOLKENBREIT: The community services are where it's at at the end of the day.

LETITIA JAMES: Yeah.

ALISON BURKE: Can I just add one thing?

LETITIA JAMES: Yes. Yes, Mr. Burke.

ALISON BURKE: I mean, I think you've heard we are, you know, certainly reporting and complying with requests on beds that are being operated, licensed, all that. I think really the system really is transitioning, and we've heard from some consumer advocates and others that we really want to provide more in the community before a crisis.

LETITIA JAMES: Right.

ALISON BURKE: So, if there's going to be any sort of review or look -- needs assessment done, it needs to look at the whole system, not just the worst place for someone to be.

LETITIA JAMES: Thank you. Thank you all. I appreciate you.

LEONIDAS BELL: Thank you.

JED WOLKENBREIT: Thank you.

ABISOLE FATADE: I'd like to call on Gabriel Valles to speak. Thank you for your patience. Have you been sworn in, Gabriel?

GABRIEL VALLES: Maybe. Somebody told

me I had to be sworn in (indiscernible).

ABISOLE FATADE: No problem. Please keep an eye out for the 30-second warning. Please proceed.

GABRIEL VALLES: All right. So firstly, I want to thank anybody for inviting me anywhere to talk about anything, right? Like I'm not that important. My name is Gabriel Valles. I'm a representative of 1199. I also work in mental health. I'm a senior clinical technician in Health Alliance Hospital in Kingston.

After listening to like all these people speak, I realized that like I had no idea why I was even showing up, right? Like, we've had a consistent fight over the loss of our beds. Health Alliance Hospital at the beginning of COVID was instructed by Governor Cuomo to allow the area where our mental health beds were and turned them into overflow for COVID-19 beds.

I'm going to say it was under the guise of COVID because there was never ever real any intention on returning our beds.

LETITIA JAMES: Those beds haven't been returned as of today?

GABRIEL VALLES: As of today, they

haven't been returned. However, there was an announcement they were going to return 20 of our 60-some beds.

LETITIA JAMES: When did you get that announcement?

GABRIEL VALLES: We -- I want to say middle of May.

LETITIA JAMES: Okay.

GABRIEL VALLES: Now, I'd like to point out though that the removal of beds was back in 2020. This is a two-year process, and it wasn't initially even going to be encouraged by Westchester themselves, right?

This is like a million people and politicians and community advocates and activists throughout our whole area that had to get together and say, you know what guys, this might not be the right idea, right? Like mental health services increase or decrease, right? One is going to help; one is going to hurt. I mean, it's simple math. You never get more by subtraction when it comes from the whole services.

I started out as an inpatient psychiatric tech and I ended up getting moved

into a role in the psychiatric emergency room, and I want to tell you, instead of giving you any solutions, because I have none, right, this is actually befuddling and baffling to me as well, I do want to tell you some stories.

Firstly, as an inpatient psychiatric technician, I was able to meet hundreds and hundreds of people in my community who suffered acute psychiatric illnesses. Those people became like family to me. I would see them more than my own family. There was consistent 16 hour shifts over and over and over and over again, back-to-back-to-back to where I saw my own children less than I saw mental health patients.

LETITIA JAMES: Were they repeat visitors?

GABRIEL VALLES: Yes, ma'am. They're always repeat visitors. This is not something that we have an exact science for. No one here has the miracle pill that's going to fix somebody in a day. And sometimes it takes people many, many, many, many, many tries.

LETITIA JAMES: Did you see those same people out on the street?

GABRIEL VALLES: Not anymore, I don't,

ma'am, not anymore. I don't see those same people on the street. And I miss those people. And I worry about those people and I'm concerned about those people because those are my people, right? Those are the people that come to me and I'm their everything.

That's a weird thing to state that you're a human being, but you're somebody else's everything. You might not even know them, but I am. When they come there, they're devoid of any kind of services. It's not just mental health services. They're devoid of proper housing. They're devoid of proper nutrition. They're devoid of proper clothing. They're devoid of showers. They're devoid of all of these necessary, holistic things, right, for these people to be successful anywhere.

If you were today to tell me, an average baseball player at best, to go play for the Yankees and hit a home run and then supply me a whiffle ball bat, chances are I'm striking out. And that's what we every day ask our mental health medical professionals to do. That's what we every day ask our community activists and our mental health associations. That's what we every

day ask these people to --

LETITIA JAMES: That's a great metaphor.

GABRIEL VALLES: -- to do. And it's a shame. It's a great metaphor, and I'm glad that we could be poetic, but it's a shame because what more importantly it does is it causes people like my brother -- his name is Jason Gabriel Valles. He passed away on March 14th. It was a suicide. He overdosed on psychiatric medication. He was in a North Carolina Hospital, and I don't do too many details, but on March 13th he gave me a call and we had the best conversation that we had ever had in his entire life, super positive and it was just like so many moments throughout this 39-minute conversation that I had with my brother where he was coming to terms with like all these epiphanies like, you know, he said, Gabe, you know, my kids have been with my mom and I'm really mad that she took them, but I come to the realization that maybe I'm just not going to be the one that's ever going to be able to take care of them. And all these epiphanies, and all I kept feeling was man, this kid's doing good, he's finally doing good. And the next day he killed

himself because it wasn't peace with the fact that he wasn't going to be able to take care of his kids, it was peace with the fact that he no longer thought that he had to. It was -- it was going to be okay as long as he took himself out, which is what he did.

Deaths from mental illness do not manifest physically. You will not walk down the street most of the time and see a guy kill himself in the middle of the street. What you will see is a person who hasn't taken care of themselves for the past year and a half, two years, and they come in with increased, you know, liver enzymes or they come in with heart problems or they've been smoking 2-and-a-half packs a day on the street and now they can't breathe and they have COPD.

The deaths that we see from mental health do not manifest as a mental health death, right? Not most of the time. Eighty-five percent of the people that I saw at the beginning of my career in mental health are no longer coming into the hospital and it's not because they don't live locally. It's because it's not available.

So, what do we need to change? We need to change a lot of things. First of all, we need to value people with -- value the employees with the same value -- value a medical professional and pay us equally.

Second of all, you need to stop doing censuses and saying, okay, that's two techs and two nurses for this census. Let's go by acuity, some of these people are sicker than the others, require more help. Mostly, we just have to remove the stigma that mental health is not an illness that's killing people, because on the daily it is. And the only way to do this is to treat the professionals taking care of the people equally to how you treat other professionals taking care of medical people. That's a real belief of mine. Thank you for your help, and I'm glad you let me come here.

LETITIA JAMES: One last question before you leave, Mr. Valles. What happens when someone comes to you for emergency care and there are no beds? Where do they go? What do they do?

GABRIEL VALLES: Ma'am, so this is the saddest part. So, if you come into me to an emergency room in a hospital where I have four

bedrooms, right, like they're lined up and they have very minimal furniture in the bedroom, a psychiatric bedroom may only have a rubber bed in it with a plastic base that's bolted to the wall and not another thing in the room, we'll give you two or three blankets and you will wait there until we can find a bed, you know, that will be legal based on our (indiscernible) laws. We want to get you to the closest facility.

Unfortunately, there are no beds. We're not sending people 15 minutes away from home. Our nearest bed once you get out of our area is 45 minutes away. The next nearest bed is 1-and-a-half hours away. So we're asking the people at the lowest socioeconomic status to now find support that can come visit them as many as 2-and-a-half, 3 hours away.

And God forget it -- God forbid it's a child that has to come into the hospital because you can just add that by exponents. You will not get a child in bed for less than a week. And if you do get a child in a bed for less than a week, you ain't confident it's a good bed.

And I'm going to tell you right now, we love our children and we do the best we can. But

we're devoid of services. You asked me to hit a home run with a whiffle ball bat. I can't do it. I'll kick the -- I'll kick the heck out of that ball right down the field. We might get a single, but I ain't going to be able to hit that home run for you.

If we live, you know, within our capabilities, we'll save a lot of lives. But until we achieve what we're capable of, we're going to keep failing.

LETITIA JAMES: Thank you, Mr. Valles.

GABRIEL VALLES: Thank you.

ABISOLE FATADE: I'd like to ask the three members from PEF to please stand -- come forward, Michele Rosello, Leticia Rivera and Carl Ankrah. Thank you for your patience. Have you all been sworn in?

MICHELE ROSELLO: Yes, we have.

ABISOLE FATADE: All right, thank you.

MICHELE ROSELLO: Thank you.

ABISOLE FATADE: Once you're settled, Michele Rosello, you can start. Thank you.

MICHELE ROSELLO: Good afternoon Attorney General James and distinguished panel. My name is Michele Rosello. I'm a proud social

worker with 20 years of experience in mental health. I am also the Public Employees Federation Council leader at Creedmoor Psychiatric Center.

I'm joined today by my fellow Public Employee Federation Council leaders Leticia Rivera from the Bronx Psychiatric Center and Carl Ankrah from the Rockland County Psychiatric Center.

On behalf of Public Employees Federation's president Wayne Spence, we appreciate the opportunity to appear today to share our thoughts and expertise on the barriers to mental healthcare in New York.

PEF, Public Employees Federation, represents more than 50,000 professional, scientific, and technical staff employed by the state of New York. This also includes all of the professional treatment staff at the New York State Office of Mental Health.

My colleagues and I will briefly review how we got to the current state of affairs and how our current -- how our current governor, Governor Hochul, has approached the challenges of addressing the systemic challenges she inherited

to tackle this crisis and what we believe is the appropriate next steps to address this challenge now and in the future.

Leticia?

LETICIA RIVERA: Good afternoon. My name is Leticia Rivera, and I am a PEF council leader at Bronx Psychiatric Center. To understand what is happening now, we must look at what has happened in our state mental health service network over time, and we believe that the current challenges facing the state are a direct result of our former Governor Cuomo's failed transformation agenda.

This failure is clearly demonstrated by the rise in suicides, crimes, and homelessness in every community across the state. The reality is that the transformation agenda was simply a more palatable way of saying privatization. That was the agenda that the state mental health services network and the decade-long changes have absolutely hurt New Yorkers suffering with mental illness as well as the state's ability to respond in current mental health crisis.

For these reasons, PEF continues to advocate that the New York fund our future by

expanding public services for mental illness and other risk individuals to ensure appropriate and continued access to quality care for all New Yorkers and with the goal of keeping -- affected by New Yorkers close, approximate to their families and other support systems.

While private -- while private providers play a crucial role in continuum of mental health care, they are ill-equipped to serve as a safety network as they have no duty or no obligation to render treatment and may not or willing to provide needed treatment due to economic or other reasons.

The state long divestment for mental health services has hurt the ability of New Yorkers to access appropriate services quickly and efficiently. The Office of Mental Health has reduced inpatient beds substantially -- I'm sorry. Excuse me -- stabilization capacity for adults, youth, and forensic patients by more than 2000 beds since 2016.

OMH has shed more than 25,000 positions since 1990. Staff reduction has caused a reliance on overtime to explode. Since 2011, overtime at OMH has increased 65 percent, and in

2020 alone caused New Yorkers 157 million in overdue -- I mean overtime alone.

More importantly, however, fewer staffing affects access to care and quality of care New York receives. Over this time, OMH has slashed funding for critical programs like state operated ACT teams which provide immediate care for those in crisis.

Even in the state of reinvestment savings for the reduction of private operation providers, the state's overall inpatient bed capacity still does not meet the basic minimum standard prescribed by the treatment advocacy center, which recommends 50 beds per 10,000 Residents in New York. It's short by more than 1700 inpatient beds.

CARL ANKRAH: Good afternoon, AG James and the rest of the staff. My name is Carl Ankrah, psychiatric nurse practitioner at the Rockland Psychiatric Center, the largest state-run psychiatric center in the country.

As you said a few minutes ago, AG James, we didn't get here yesterday. This has been years of underfunding and undercutting, and I want to offer the records this statement that

was offered by (indiscernible) that there's no health without mental health, and the health of our economy of the great state of New York depends on the health of the people of New York state as well as their mental health.

Over the years, we as a union and as members of Public Employees Federation have fought vigorously to defend the cuts by the previous administration. So we are grateful to the current administration for offering us the opportunity to offer our consideration of the direction which mental health is going right now.

But we have to do more. We have to do more. As others have testified, people with mental illness die 25 years compared to -- earlier compared to the general population. And we must do everything within our power to help provide the needed -- our youth, right?

So, counties in Oswego and surrounding areas are going to lose inpatient psychiatric beds. These are the future leaders of tomorrow and we are cutting the beds necessary to stabilize those who need it, right?

Recently as part of the governor's funding, about $15 million -- $21 million was

allocated for what we call ACT teams. These teams were given to the private sector. We respect the fact that the private sector have a role to play in this. But the unique services that we, members of OMH, the staff deliver cannot be allocated to the private sector. Additional monies were also offered to again ACT, assertive community treatment teams for adults.

This -- bearing in mind, AG, that the -- already some of these teams have already been suspended and these monies are being afforded to the private sector. Again, with all due respect, they have a role to play but they cannot replace the services we offer. We serve some of the most challenging cases in New York. We serve most of -- marginalized, uninsured clients, people who cannot go to places like Columbia, the ivy leagues of the hospital's, right? So, we must not balance the budget and save on (indiscernible).

Lastly, I want to offer that over the years, consolidation, outsourcing, and understaffing, taking the -- have altogether taking a burden on the lives of New Yorkers and we must do everything. So, it's our hope AG

James that will work together in the years ahead to make sure that those beds that have been taken offline are brought back. Thank you.

LETITIA JAMES: Thank you. I want to thank members of PEF for your testimony. So it's your position that AST teams were an attempt at privatization?

CARL ANKRAH: AC teams.

LETITIA JAMES: AC teams.

CARL AHKRAH: Right.

LETITIA JAMES: Was privatization?

CARL ANKRAH: That's correct.

LETITIA JAMES: When they could have been done in house by members of PEF.

CARL ANKRAH: That's correct.

LETITIA JAMES: Were there cost savings as a result of this?

CARL ANKRAH: As -- not really cost savings because I've always believed that if we try to save costs at the end, we spend more. The clients who are serviced by ACT teams are very challenging and they cannot be serving these private sectors. The outcomes speak for themselves.

LETITIA JAMES: Why were some of these

teams suspended? You don't know?

CARL ANKRAH: Reasons beyond our understanding.

MICHELE ROSELLO: You had asked earlier about the -- you said ACT, the mobile crisis team, the (indiscernible), the inpatient, outpatient, all those things exist, yes, they do, but they have been decreased, marginally decreased. We don't have people to staff it, okay? We have the programs there but there's nobody to staff it.

And a gentleman earlier spoke about the peers in the community. We don't have peers stable enough right now, because people are just being shunned out of the inpatient services. Discharge starts upon impatient for the beds and we need those beds and, you know, it's a wrap -- all wraparound services. Everything goes kind of like in a circle.

But when you've decreased everything on each piece, everything falls. You know what I mean? So, all these programs, they're in place but they are decreased. They don't have all the people to staff and to run them and to give the quality care that's necessary.

LETITIA JAMES: And when hospitals consolidate, is there any oversight to ensure that the same services are being provided at the same level?

MICHELE ROSELLO: I don't believe so. I have worked inpatient, outpatient. I'm currently in an outpatient transitional residence where we're supposed to be able to ensure over six months that these clients who have been discharged from the inpatient unit, who have been taught on the inpatient unit how to be in the community, sure those skills up so when they get into the community they can work better. But guess what? I don't have staff -- not me. The facility doesn't have staff to teach them. We don't have the rehab people. We don't have the nurses. We don't have the social workers. We don't have the psychologists. So then when they get discharged, when they're finally able to be discharged, they come to the residence and now we have to work with them, but we don't have staff to work with them. No rehab.

LETITIA JAMES: And the reason why you don't have staff, the reason why people are not coming in, what, low salaries?

MICHELE ROSELLE: Low salaries. Nurses don't have the proper salaries. Social workers don't have the proper salaries. Psychologists, all the behavioral health, all-stars, if you want to say, don't have the proper salaries. They're not coming to the state.

That is why we are working on funding our future. We're looking for making state workers great again, because we need the state workers to be there to help with these people inside the facilities and outside of the facilities, inside the communities, inside the hospitals, inside -- somebody mentioned a crisis center like where these centers -- place -- I've never seen one. Where is the place that you're supposed to go that's not a hospital, that's not an ER, that's not a respite?

GINA BULL: There's only two in New York City.

MICHELE ROSELLE: Oh, thank you very much. Well, this is why I have not seen it.

CARL ANDRAH: AG James, if the consolidation with -- between SUNY upstate and Hutchings PC goes through, we ask that OMH should not be given the authority to oversee this and to

measure the outcomes. It should be an independent entity to be able to monitor the outcomes. Thank you.

LETICIA RIVERA: Leticia James, so, we also need more --

LETITIA JAMES: Yes, Leticia.

LETICIA RIVERA: I'm sorry, okay? The Bronx came out. We need more programs like the ACT team. We need more programs like the ICM program, the mid team as well, family care. We need a lot more outpatient programs in our communities to be able to service these people when they get discharged from the hospital. We can't continue to discharge them out to the same place and doing the same thing over and over again. That's insanity, you know? And we're not doing the right thing by our patients.

LETITIA JAMES: I appreciate you and I appreciate all you do for the state of New York. Thank you.

CARL ANKRAH: Thank you.

LETITIA JAMES: Can we call in -- can we combine the next two panels? There's one person in the other panel, Ms. Tamara Biguel, and -- Biguel, excuse me, and Kimberly Blair and --

ABISOLE FATADE: Julie Leclaire?

LETITIA JAMES: Yeah. And Roy and Lucille.

ABISOLE FATADE: Okay. Hi, Tamara. Please proceed while we get everyone else in. Thank you for your patience.

LETITIA JAMES: Can we join her with the others, the next panel? Okay, thank you. Okay. You can begin.

TAMARA BIGUEL: Okay. Thank you very much for letting me speak. I greatly appreciate it.

LETITIA JAMES: I apologize for the lateness.

TAMARA BIGUEL: My name is Tamara Biguel. I am an independent advocate, but I'm here as a parent. My son was 9 years old when we first tried to get into a hospital. He had tried to hang himself. We brought him into a hospital, Stony Brook CPEP. They did not keep him for impatient.

He further decompensated for several months. It took four different ER visits and a call from his psychologist to his own -- to his own CPEP to -- the outpatient psychologist to the

own -- to his own CPEP in order to get him admitted.

My son has been through four inpatient hospitalizations. We've done it before COVID and after COVID. COVID -- the problem started way before COVID. The long wait times, stays in the ERs, but the worst was during COVID where my son was sent to South Oaks Hospital. He was -- they were on lockdown. He was there for eight months waiting -- he -- they decided on the second day of his hospitalization that he needed longer-term services at Sagamore Hospital. He waited there eight or -- sorry, two months for a bed. Of those nine weeks that he was there, about eight of them were -- about eight of them were on lockdown because they kept having COVID outbreaks, which meant that there was no visitation whatsoever.

My son during that time was daily attacked by one particular child to the point that he was punched in the face and kicked in the groin. After have -- you know, one incident, two incidents, okay, when it got to four or five I said this is a pattern. It's happening every day. Clearly somebody needs a one-on-one.

Something needs to happen.

Nurse manager said well, he says things to other kids to make them upset. My son has mental health issues. Just because he's -- you know, it's up to you to keep him safe. I then reported it to the Justice Center.

I waited months and months, eventually found out that the hospital -- the response to getting punched into the face made my son very upset. So, he went off into a separate room with staff. Staff kept coming at him, you've got to calm down, you've got to calm down, you've got to calm down.

Sometimes de-escalation means you step back for a minute, stay in the room, step back. But their response to his reaction to the trauma of being punched in the face was to put him in restraints for 30 minutes, which is -- give him IM meds, two different types.

When I looked at the medical records because I eventually insisted they give them to me, there were varying doses. Some of them seemed almost twice as much. So -- and it's not because it was different meds. I know the meds. I have the records.

I had called the Justice Center, asked them to follow up. I was told that the -- and I said I want to know if staff was negligent in how they were approaching these incidents time and time again, as well as asking if the restraints policies were followed, because according to restraint policy, once the individual is -- has stopped fighting, you are supposed to let them out.

He was restrained several times during his period and they were regularly -- and it was always 30 minutes. There are severe violations that went on. I have the documentation, report -- it's been 15 months. I still haven't received the Justice Center report. OMH sent a letter saying that this was a serious incident, that they had to give it to me because of Jonathan's Law. I worked with DR New York and I still haven't received it yet.

I am following through with all the protocols. None of those things can be followed up on. I've seen kids restrained that -- while I was visiting there that were calm. They're not supposed to stay restrained when they're calm.

I heard nurses threaten 30-minute

restraints on kids. You're not supposed to threaten restraints. But the system of care on Long Island in general has completely collapsed. There are not psychologists to treat kids after they have suicidal attempts.

Kids who had swallowed large numbers of pills are waiting six months to a year to see a psychiatrist. The -- there are no -- there are no -- everyone from the psychiatrist to the family peer advocates to the case managers are not -- to our direct care staff who are on the front lines are not paid appropriately.

So, they're saying -- and this happened before the great resignation, before COVID. There aren't enough staff to run the hospital. There aren't enough staff to run the programs for home services.

You have the same people having two to three full-time jobs just to keep their family afloat. It has complete -- there's no oversight and that -- and not only is there no oversight but it's not publicly available. We need wait times and beds counted and how long people are waiting for service -- the services they need, not just how long is the wait but how many people

are waiting, and all of these things should be reported. OMH needs to have accountability and not only that, the idea of having for-profit and non-for-profit company -- agencies running these services out on the -- on the island, no one's sharing what works and sharing it amongst everybody else so that everything gets lost.

And there's no one holding them accountable, they just say oops, we don't have the staff. And so we have 100-people caseloads for some of the sickest kids.

I -- my son finally made it to an art - a hate -- a needle in a haystack RTC. I live on Long Island. He's in Lake Placid but he's actually getting the care he needs at Mountain Lake Academy. However, their program which is actually working, which is trauma based, which has autism training, which has a full program, isn't being perpetuated throughout the state.

The big picture here is that we have no accountability, no enforcement of policy, and even when things are reported, they're not accessible so that -- so that public people can follow up on it. Parents are at the breaking point because we cannot get the health care for

our children. We need -- we need people to step in.

LETITA JAMES: Where's -- the Lake Placid program, what is the name of it again?

TAMARA BIGUEL: Mountain Lake Academy.

LETITA JAMES: Mountain Lake Academy. So, I agree with you, accountability, transparency, with respect to all the issues that you mentioned. Caseloads, waiting time, bed counts, services, no data at all. And --

TAMARA BIGUEL: And like everybody else said, the beds that they report as being opened aren't staffed. And they make extra-long reviews of and make reviews of case files, so that time isn't counted either. But the big thing is restraints.

LETITA JAMES: Yeah.

TAMARA BIGUEL: We need to make sure that there is oversight on restraints and it shouldn't take, you know, six months to review a restraint.

LETITA JAMES: No, I agree with you. Ms. Biguel, correct?

TAMARA BIGUEL: Yes.

LETITA JAMES: First of all, let me

just say that I'm glad your son is in a good place.

TAMARA BIGUEL: I'm already signing up for services. I don't -- he's, they said maybe six months to a year if he doesn't stall out in in a step in their program. I'm already signing up for services and begging my way on because I want to make sure that he has people in place and the waiting lists are over years.

LETITA JAMES: Have you submitted written testimony with respect to your experience?

TAMARA BIGUEL: Yes, I have.

LETITA JAMES: Okay, good. Thank you. We will review it and I really appreciate you for sharing your story.

TAMARA BIGUEL: Okay. I have the backup documentation.

LETITA JAMES: Thank you. Thank you so much.

TAMARA BIGUEL: Thank you.

ABISOLE FATADE: Thank you. Now, I'd like to ask Kimberly Blair, Roy and Lucille Ettere, Julie Leclair, to please come up. Thank you. Thank you for your patience.

LETITA JAMES: Sorry for the wait.

ABISOLE FATADE: Hopefully you've all been sworn in. Whenever you're ready, Kimberly Blair, please proceed.

KIMBERLY BLAIR: Well, good evening Attorney General and members.

LETITA JAMES: Good evening.

KIMBERLY BLAIR: First, I'd like to thank you for holding this space to hear from peers such as myself who are living with mental health conditions, and their loved ones, and their community-based organizations that really strive to help them along the recovery.

My name is Kimberly Blair and I'm here testifying on behalf of the National Alliance on Mental Illness of New York City or NAMI NYC, where a Grassroots Mental Health Advocacy Organization here in the city. Today, I'd like to highlight findings from an E.R. survey that our organization alongside the Manhattan Together Coalition and a number of community partners conducted among people seeking psychiatric services at emergency rooms across New York City. Launched in September 2019, our organizations administered two separate surveys. The first one

was among patients and consumers, which consisted of 25 questions and the second survey was among family and friends consisting of 29 questions.

From our results, we found several themes on what works with the psychiatric hospitals and what still needs improvement. Some of the things you actually have already heard today. One of the things we learned was the need for family members to remain with the patient. In our survey, patients allowed to remain with a family member were more likely to report that one they were treated with respect, they were treated with emotional support, that they would recommend that hospital, that they felt involved in care decisions, and that's actually from the patient perspective, not the family perspective, and that their confidentiality was protected.

Second theme we found was the need for shorter wait times in the psychiatric E.R. and better triage protocol. From the patient and consumer perspective, shorter wait times, so less than 30 minutes were associated with an overall positive experience at the psychiatric hospital and increased the likelihood that the patient would actually recommend the E.R. From the

family perspective, nearly 50 percent of respondents said that the patient actually waited over an hour to even be greeted at intake for the reason for their visit. And nearly 85 percent of respondents stated that the patient spent anywhere from over three hours to more than three days in the emergency room.

The need -- the third thing we found was the need for hospitals to provide more follow-up resources and information. Of those who were not admitted to the hospital, 62 percent said that they were given no information or referrals to follow up care, which we know that causes a revolving door. And of those who did receive referrals and information 55 percent said that information was actually not helpful. Fourth, we found that there was a need for better training of medical professionals and other hospital staff, as well as better quality care standards and enforcement of those standards.

From the patient and consumer perspective 59 percent of respondents said that doctors and hospital staff did not even inform them of their privacy rights. Nearly a quarter of respondents said that they disagreed or

strongly disagree that doctors, nurses, and other staff treated them with respect. From the family perspective, a majority of respondents said that they were treated with respect but actually only 34 percent said I would recommend this hospital psychiatric E.R. to others.

And I know we're pressed for time. I did submit a very thorough written testimony, but something I want to leave you with is one person in our survey and I quote, was commenting on, you know, the several issues in terms of the inadequate size of the psyche E.R. the lack of privacy and rooms for patients and extensive waiting time in a hallway. And I quote, "That person was kept on a gurney in the hallway of the psyche E.R. surrounded by other patients being watched by security and with fluorescent lights on for three nights and two days." That is unacceptable.

LETITA JAMES: Did any of the emergency rooms use restraints? Was that in your survey?

KIMBERLY BLAIR: I would have to follow up with that information but anecdotally we did hear -- we have quotes from folks that did talk about forcible restraints.

LETITA JAMES: Before we go on to the other panelists, tell me the geographic area that covered the survey. Is it all of New York City?

KIMBERLY BLAIR: We tried all of New York City, we had limitations due to the COVID-19 pandemic. We did not have access to many hospital settings. So, we have an over estimation of Manhattan hospitals.

LETITA JAMES: Okay. And what period of time did you take this survey?

KIMBERLY BLAIR: September 2019 to January 2020. We are actually launching a second portion of the survey in the next upcoming months to follow-up.

LETITA JAMES: How many people were in this survey?

KIMBERLY BLAIR: It was nearly 60.

LETITA JAMES: 60, okay.

KIMBERLY BLAIR: So, it's a small sample size. That's why we want to launch it again.

LETITA JAMES: And your next survey will cover the other boroughs?

KIMBERLY BLAIR: Correct.

ABISOLE FATADE: Lucille, take a seat.

LUCILLE ETTERE: Thank you. Hi, thank you for your time today and for listening to our testimony.

LETITA JAMES: And thank you for waiting I apologize for the wait.

LUCILLE ETTERE: Oh, that's fine. We're happy to be here and thank you for having us. My name is Lucille Ettere. I'm from Somers in Westchester County. I'm a board member of NAMI New York State and also NAMI Putnam County. My husband Roy is here to my left. He is also a board member of NAMI Putnam County and he answers their warm line.

LETITA JAMES: He answers their -- what did you say?

LUCILLE ETTERE: He answers their warm line. The NAMI warm line.

LETITA JAMES: The warm line, okay.

LUCILLE ETTERE: We both volunteer with the Putnam County suicide task force in Carmel and we'd like to share our story with you and ask for your support to help the severely mentally ill and prevent them from turning to suicide to stop their pain. Our daughter Nicole took her own life September 19, 2017, after suffering with

a mental illness called body dysmorphia.

She was 37 years old and was a very vivacious woman who worked diligently in the medical field for over 10 years prior to her illness. She struggled with anxiety and depression and in March 2017 was unable to continue working. For seven months, she isolated herself from family and friends only to go out for visits to the doctor and therapist. She was briefly hospitalized five different times. After five suicide attempts from June 2017, through August 2017. So, a short three-month period, we were helpless and tried tirelessly to get her the help she so desperately needed. The five hospitals failed to provide her with the appropriate treatment.

Missteps included giving her medication without testing her blood to see what she had in her system, keeping her for a few days and releasing her with no concrete discharge plan and many times the discharging -- discharging her simply to an appointment with a therapist in a different area or county or psychiatrist. Although medical histories were taken at each hospital and our E.R. visits lasted no longer

than or no shorter than an hour and a half to two hours each intake. So, they had plenty of information. No collaboration was done with the previous doctors or hospitals.

Nicole could have been helped if each hospital made a proper diagnosis, recognized the severity of the mental illness and collaborated with the prior hospital. It would have helped if each hospital had a specific plan to deal with someone with multiple suicide attempts rather than put her in the general population with medication and general group sessions and classes. There was very limited individualized attention which these patients absolutely need when entering the hospital emergency room after a suicide attempt. And if that person has made prior suicide attempts, that person should be given individualized attention to determine why these multiple attempts happened and or continue to happen. If Nicole was given therapy in addition to medication, if she were assigned an advocate to guide her through the treatment, if a proper discharge plan was put into effect and if she had received follow up support after discharge to ensure she was adhering to their

discharge plan, our daughter might still be here and I would not be speaking before you today.

We have a daily void in our life. We request that you hold the hospitals accountable and have them put in place an in-depth evaluation and diagnosis that they collaborate between doctors and hospitals both within their own hospital and between previous hospitals where the patient was seen or treated. Create a red flag law which will alert the hospitals, the doctors, and social workers, and the psychologists, that the patient experience the previous suicide attempt and needs intensive treatment. Make sure that there are enough beds available in all hospitals to care for these patients and that the patients are kept long enough to receive proper care. She was actually in one of the hospitals, the second hospital discharged after two days to this -- actually to the hallway. They didn't even want to speak to me at that point and she had gotten approval from the insurance company to stay longer. They felt that they couldn't help her and she was crying that night because she was in pain with her shoulders and they told me to take her to the E.R., they wouldn't even treat

the medical issue.

NAMI New York State has presented a law called Nicole's law to the legislative session prior to COVID and they will reintroduce this in the upcoming session to help protect the mentally ill in all of our communities and to prevent the loss of life by suicide. Thank you for allowing me and my husband to share our story with you. We wish to collaborate with you not to fill the void in our family but to ensure Nicole's experience will prevent other families from experiencing such a void. No family should share such a loss. We have established a foundation to help those who have lost a loved one to suicide to and who have experienced the same loss that we have by beginning to create memorial gardens where people can visit reflect and begin to heal.

Please protect the most vulnerable of the mentally ill and ensure that there are enough beds and that they have the services available to help them. Thank you very much.

LETITA JAMES: Thank you. Before we go to you, let me just ask -- first my sympathy to you and your husband and to your family.

LUCILLE ETTERE: Thank you.

LETITA JAMES: Do you know who's carrying Nicole's law? What assembly member or senator?

LUCILLE ETTERE: Well, Senator Carlucci had sponsored it but he's no longer in the position that he's in. And we also have Senator Brouk -- is it assembly member? I'm sorry and then Senator Katko kept supporting that and Assemblyman Burn has given his support.

LETITA JAMES: And how many times did -- was Nicole in the emergency room, and at what hospital? Was it several hospitals?

LUCILLE ETTERE: She was at several hospitals. She was started off at New York Presbyterian Hospital down here and they kept her for nine days and then discharged to the street of New York with her slippers on and I didn't even know she was being discharged. And then she was at Putnam Hospital, Lawrence Hospital, and Northern Westchester Hospital, and then New York Presbyterian for outpatient. But her last hospital stay which was for seven days, they discharged her at the nurse's station and gave her -- her discharge plan was outpatient at New York Presbyterian in White Plains 10 days after

her discharge. And our question to them was what do I do for 10 days?

LETITA JAMES: And was there any collaboration amongst these hospitals?

LUCILLE ETTERE: None whatsoever. As much as they knew -- and they all knew the whole history, so they knew who it was, they knew the if, ands, you know, when and who.

LETITA JAMES: And were there any community-based organizations or services in and around where Nicole lives?

LUCILLE ETTERE: There are yes, because we're in Westchester County but we're also close to Putnam County. So, there are but there was nothing ever offered to her besides the outpatient services at New York Presbyterian.

LETITA JAMES: My sympathy to you and your family.

LUCILLE ETTERE: Thank you, very much.

ABISOLE FATADE: Julie, please try to move the microphone closer to you.

JULIE LECLAIR: Oh, okay. Can you hear me? Oh, there I hear me, okay.

ABISOLE FATADE: Thank you.

JULIE LECLAIR: Okay, well, thank you,

I appreciate all of you having me testify. I'm really honored to be here.

My name is Julie Leclair and I wear multiple hats. I am a Ph.D. clinical psychologist with a private practice, and I also am the mother of a daughter with bipolar disorder. My daughter Alexandra Leclair who went by the nickname Alix with an I, she named herself that, and she got mad when I didn't call her Alix. Anyway, so she was a freshman at Dartmouth College and she got diagnosed with bipolar disorder her freshman year.

And then she ended up having a hospitalization for mania and she tragically passed away at age 25 in 2016 and my daughter was really quite a powerhouse herself, she advocated for those with a mental illness, she published a paper while still in college to advocate for those with a mental illness and she helped to fight the stigma on campus through active minds.

Unfortunately she herself got stigmatized while at Dartmouth, the students there were not always understanding, especially because she e-mailed the entire freshman class from the psychiatric unit while she was manic and

so that caused a lot of issues for her and she ended up transferring to New York University and at New York University she absolutely excelled there, she went there for 2.5 years doing really great and while she was there she even studied abroad in Germany.

But then what happened is my father, her grandfather to whom she was very close, passed away in 2012 and Alexandra had another manic episode and unfortunately the hospital discharged her way too early and she was in New York City and she went to a New York City bar while she was still manic and the bouncer evicted her from the bar and while she was being evicted there was a glass panel that was in the door and the glass panel broke and that caused damage more than $250 and my daughter was charged as a felon, and she was put in a prison unit and she was put in a prison unit, a hospital and some of the people who were there with her, she was a college student, were murderers.

And so, that's where she ended up. And in fact over 60 percent of those with a mental illness in New York State, who are incarcerated in jails and prisons do have mental health

issues, and also many of those who are homeless on the streets also have mental health issues. And in fact, many times when my daughter would become manic, she would become fixated on becoming homeless and would want to run away onto the streets and live on the streets.

And my daughter did do very well with her hospitalization. She next had a purely psychiatric one. In her case, she was very lucky, her charges were dropped and she was able to go forward and she went on to have other hospitalizations, mainly for mania, but a few of them were also for depression, one for a very serious suicide attempt. And sometimes when she was admitted to emergency rooms, there were no hospital beds that they could find and they had to really look. So, one time she went all the way from a New York hospital bed emergency room to Connecticut, and she was very lucky to even get that bed in Connecticut because otherwise she would have been released in an unsafe state of mind.

And all these hospitalizations really made a difference for her. And what ended up happening is, it was a beautiful thing, but she

did not get to finish college before she died. But New York University post humorously gave her a college degree and hopefully from up in heaven she can see it, and her degree is hanging in her bedroom on her wall. And what ended up happening at her funeral is that many people came to the funeral and I didn't realize it, but they came up to me and they were actually people who overlapped with her on psychiatric inpatient units.

And they came up and told me, one of them said to me for example your daughter was like a tortured soul sent down from heaven and she uplifted me and many of the other people told me she uplifted their spirits too. And even in the throes of mania, my daughter was able to make a difference on the psychiatric units and one girl who couldn't make it to the funeral who also overlapped with my daughter on the unit flew all the way out from California and it ended up being a snowstorm. So, we drove her to my daughter's gravesite. The girl pulled out a seven-page letter to read to my daughter Alix and she said to her she was now taking medical school classes, that she wouldn't be where she was if it wasn't

for my daughter.

That my daughter rescued her from some sort of darkness, and that she was going to name her first child after Alix. And then what ended up happening is, I really realized that at that funeral not only had I seen how much difference the hospital made for my daughter, but it made a difference for all those other women who did survive and had a sense of camaraderie and support and getting medication and treatment from being in hospitals together and also what they got individually.

And I'm here to say that I really think it's important to have enough hospital beds and that can help avoid being incarcerated, being on the streets, and also ending up dead. And I want to thank you for giving me the opportunity to do this testimony and most importantly, to give my daughter a voice even from beyond the grave. So, thank you.

LETITA JAMES: Thank you, Ms. Leclair. And again, our sympathies to you and to your family, but your daughter is smiling right now with her degree. Mr. (indiscernible), you -- tell me a little bit about the warm hotline.

ROY ETTERE: It's a number -- I'm sorry, thank you for having us. Thank you for seeing us today. Thank you for putting in overtime for that. Thank you. The warm line is a number that is on our website that if somebody needs help if somebody needs to be directed somewhere similar to 988 that's coming in July, I'll try to recommend a service for them. Most of the phone calls are just listening to them. They want to have somebody to talk to, they want to have somebody to vent with and that's probably 80 percent of the phone calls. The others are the disappointing phone calls that I can't give them somebody that's going to react in a week or two or three. There's actually three and six month wait lists for these people. How do they get help? The system is lacking. They certainly fell short of what they were designed to do. it seems like the health care system for mental health is not even broken because something had to be in place to break, that something was never there.

The warm line as much as it's intended to do good, doesn't. So, one of my questions about the health care, there's -- this is 2019.

There was $225 billion dedicated and lost from lost work. Mental health care services, in patient, that's a lot of money. Why a larger portion can be given to the healthcare workers' salaries, to the therapist salaries, they are so underpaid that nobody's going into the industry. Most of the psychiatrists and psychologists today are over a certain age, there's no attraction for anyone to join into it. We met with NAMI four months after my daughter passed, and we wanted to do something to not have her death just be another death of 46,000 people that commit suicide. That's over a million attempts. 46,000 completions. That's 120 deaths per day.

I had asked NAMI New York State, a Boeing 747 plane can hold 400-600 people. Based on 46,000 deaths a year, that would be a Boeing 747 crashing every week with every other week. two of those planes crashing. I'm not sure what airline it was last year that shut down the entire airline because two planes crashed. What would be the effect if 52 and 25 -- if 75 Boeing aircrafts crashed, what attention would be given to that? Similar attention if not more should be given to mental health. It's not something they

want to do, people that commit suicide. They have to do it.

LETITA JAMES: Right.

ROY ETTERE: They have to eliminate the pain their in. And that's -- that's it in a nutshell --

LETITA JAMES: Where do you refer them?

ROY ETTERE: I'm sorry?

LETITA JAMES: When they call you, where do you refer them?

ROY ETTERE: I refer them to MHA in Putnam County because this is part of the Putnam County board that I'm on. I refer them to an organization called Cove Care. They're also in Putnam County. 211, another number for immediate attention and I always tell them 911. If it has to come to a point where you need, you think there's a threat to the person or to you, please dial 911 and explain to the officer why you're calling him.

Don't you say 911 come to my house. Because they may come with guns drawn, without that warning, they're coming skeptical. They don't know what they're going to find on the other end. So, there's a lot of training of the

police in the counties that were at about this and I'm sure it's throughout New York State. But we were so upset with the system. We built a park, a park of Remembrance Garden, that Senator Harckham, Senator Sue Serino, the county executive and the health commissioner of Putnam allowed us to do it on their property and now we dedicated it, so heartfelt. He said that this garden is placed here in the public eye for a reason. The reason that I wanted to build more throughout New York State, which we're doing now.

We have as a matter of fact, as soon as I'm done here, a Westchester County Zoom meeting and we have one in Dutchess County. Putnam County is completed and the reason we want to do these is for people to say, what are these things popping up all over the place?

LETITA JAMES: Yeah.

ROY ETTERE: And maybe make some people aware what's going on and that suicide should not be handled the way cancer and unwed pregnancies were in the fifties and sixties. It's just not something to be ashamed about. It's something to be addressed.

LETITA JAMES: Thank all of you for

giving your stories. I truly appreciate it.

ROY ETTERE: Thank you for your time.

LETITA JAMES: And thank you so much. Bless you all. Thank you.

ABISOLE FATADE: I'd now like to ask Martin Colavito, (indiscernible), and Thank you Hewit to come up please. Thank you for your patience.

LETITA JAMES: Thank you. (Indiscernible) do we have another panel after this?

ABISOLE FATADE: I hope you've all been sworn in, in the green room? Have you guys all been sworn in? Okay, thank you.

LETITA JAMES: I apologize for the lateness of the hour.

ABISOLE FATADE: Martin, whenever you're ready, please proceed.

MARTIN COLAVITO: I want to start by saying, I agree with everybody who's been up here, okay. But I'm going to give a perspective from a rural county, and I have two asks at the end of it.

LETITA JAMES: Yes, sir.

MARTIN COLAVITO: So, thank you for

listening to me. Thanks for having us. My name is Martin Colavito and I'm a resident of Sullivan County, New York and I'm a part of a Grassroots Community Coalition called Sullivan Allies Leading Together (indiscernible). And we're comprised of community members and Boots on the Ground, human service providers. We organized about 7.5, 8 years ago. I have several-hundred members as a part of the overall coalition. We're a diverse partnership of agencies and community resources committed to improve the quality of life for the residents of Sullivan County, New York.

Before -- even before COVID access to mental health services in Sullivan County had been a challenge at best and non-existent for many as most -- for many at most due to access issues where rural county people just cannot get to services.

As a community coalition, SALT members are an integral part of many of the efforts. They're trying to address the current mental health crisis that is affecting our county. I want to stop for one second and basically say that the county commissioner of health and family

services is doing incredible work in the county. We're just -- we're just under resourced. For over a year, we've been a part of the police reform efforts in Sullivan County.

We actually drafted the template that all of the police departments used to submit on April first of last year. A constant thread during our conversations with the police departments over the past two years has been number one, they're being asked to become mental health professionals. We've all talked about that before, but the other -- the other issue, especially in the village of Monty Sullivan, Sullivan County, they've been consistently operating with less than half staff.

Capitalize, the building that they work in, has holes in the walls where vermin get in. We had a police reform meetings where rain was coming through and if police officers start the day in those conditions with that type of kind of attitude, you know, how do they end it - how do they end the day, you know what I'm saying? You know, officers are asked to kind of triage situations with people who are suffering 24 hours a day, seven days a week. Though there are

consistent efforts to address mental health crisis in our county. Sullivan County resources are compromised by the lack of available mental health and substance use disorder professionals who regularly leave our county for better wages and surrounding county. I know everybody's talking about funding and the need to, you know, pay folks livable wages, but Sullivan County, you know, health ranking wise, we're the 61st unhealthiest County in New York State.

People who are able to become certified people who are able to treat others because they need livable units -- livable wages leave. All right, speak to our mental health commissioner, speak to two Aileen Gunther, who is our assemblywoman and she'll tell you and they will tell you that people leave our county in droves, leaving us incredibly under resourced to treat this problem, all right.

From my experience as a community member along with numerous acquisitions of qualitative data, I can tell you that many people have become accustomed now to not being served, all right? One of our mottoes with SALT is hope is always in the room, but the trick is to get

you to that hope. All right, so, as community members, we try to do that.

But people are just accustomed to not being considered and that scares us and it worries me as a father, a grandfather, and a neighbor. Okay? The constant narrative from clinicians is that there is incredible pressure to comply with satisfying the required billable units of services that funding sources mandate. These folks are incredibly overworked. It's not uncommon for one clinician to have over 400 clients in Sullivan County and that's not counting the people that can't get the services, all right? I personally witnessed people on hold for hours trying to arrange transportation for service so they can attend mental health sessions. Many give up and have their condition conditions exasperated. That was the case before COVID, and it's become exponentially worse now, all right.

From March 16, 2020 until now, SALT members have been reaching out to those who are truly compromised due to mental health and substance use disorders. I do believe in my heart that many of the providers in the county

and the county itself is doing the best they can, but we are just stigmatized by the population by the amount of people who live in Sullivan County and rural counties. I attended a regional meeting with those charged with providing resources for physical and mental health disorders and I was told that there's not enough livable bodies in Sullivan County to justify more resources.

You know, I have grandchildren who I love more than me, you know, I love everybody in here's children, you know, more than me and I'll never forget that. I'll never forget that, you know, and that narrative again, if you speak to our county manager, if you speak to our commissioners, they will tell you they're faced with that all the time, all right?

There are no community health workers in Sullivan County, and in rural counties that is needed more than anything, you know, a fella said something before about engagement and it kind of went really quick, but that is the key. What we do as a community coalition is numerous times a month, we hit the roads, we hit the back roads, we hit the communities.

We've developed a navigational service that that that defends and will not compromise confidentiality, but seamlessly navigates people to care, and that's in collaboration with the county, all right? But what I'm trying to say is, is counties like Sullivan more than urban counties, need community health workers to get out there, engage people and have that connective tissue with the people who are going to provide hope. I appreciate being a part of this. I really, really do. And in conversations I've had before with folks in the state, I would ask two things. Number one, you know, start to kind of shift the paradigm in regard to service rural counties, all right? And number two, you know, if you guys want to come up, we'll give you a tour, I'll buy you a cup of coffee. We'll have a conversation and we'll be able to kind of start some really good stuff. But again, I'm begging you to consider that rural counties, you know, need help as much, if not more than urban counties. We all need help. Thank you very much.

LETITA JAMES: I look forward to coming up to Sullivan County and I look forward to you

buying me coffee.

MARTIN COLAVITO: I make very good coffee's, I'll buy you one too.

LETITA JAMES: I'm going to hold you to that.

MARTIN COLAVITO: Well, thank you very much.

LETITA JAMES: Is SALT a volunteer?

MARTIN COLAVITO: It's a community-based coalition. We started it seven years ago because of the abject need to navigation for service in our county. You know, our overall goal is to compassionately and considerably navigate people to service and I know I'm running over, I apologize.

LETITA JAMES: That's okay. Ryan, let's make sure we get coffee, okay?

MARTIN COLAVITO: Thank you, very much.

LETITA JAMES: Thank you, sir. Yes, ma'am.

EVELYN GRAHAM-NYAASI: Good afternoon. My name is Evelyn Graham-Nyaasi, and I'd like to thank you for allowing me this opportunity to testify.

LETITA JAMES: I apologize for the

lateness.

EVELYN GRAHAM-NYAASI: Hm?

LETITA JAMES: I apologize for the lateness.

EVELYN GRAHAM-NYAASI: It's okay. I'm an advocacy specialist and I work at Community Access. I'm also a steering committee member of Correct Crisis Intervention Today, New York City. As a peer with lived experience, which means ones who has recovered and successfully navigated the mental health system. I can testify that one of the problems with New York City mental health system can be traced back to the many forced hospitalizations that occur because of a police response to those who are experiencing a mental health crisis. That's why they don't have some beds. I was forced hospitalized, taken out of my home by police for no reason. I was not experiencing a mental health crisis. I was sitting on myself quietly when someone knocked on my door and it was the police. A family member had called 911 and told the operator that I had a knife. Eight to nine police officers showed up and an officer told me that I had to go with him.

No one asked me any questions or found

a knife near me, but I had to go with him. I was afraid. So I put on my coat and shoes and grabbed my medication because they told me to bring it with me. The officer escorted me downstairs and when I got outside, he asked me if I wanted to go in the police car or the ambulance. I chose the ambulance. Another police officer said that he would ride with me. They dropped me off at Bellevue Hospital, which was a continuation of my nightmare.

I waited three hours before a doctor saw me and when I told him that I needed my blood pressure medication, he ignored me and told me to go back to the waiting area. I didn't get my blood pressure medication until two days later. Unfortunately for me, it was a three-day weekend and I was stuck in a place where I did not belong. We were locked up like animals. People were screaming, yelling, and banging on windows. I was scared to death. I was also angry that a family member lied about me, angry that I was forced to go to the hospital, and angry when I learned that I was stuck there until Tuesday.

When Tuesday finally came around, I was taken upstairs to the ward and wasn't released

until two weeks later. I wish that the police officer had at least asked me questions and listened to my responses before telling me that I had to go with him because I wasn't acting violently in the slightest way. I also wish that there was support systems available that included appear someone like me with lived experience like the one CCIT NYC proposes to prevent me from being hospitalized in the first place. Correct Crisis Intervention Today, New York City, is an organization consisting of 80 plus mental health organizations which initially favored all New York City Police Department Police be trained in crisis de-escalation, but after 18,000 police officers were trained and millions of taxpayer dollars were spent. People experiencing a mental health crisis, still wound up dead when the police intervened. Most of the deceased were minorities.

CCIT NYC proposed mental health crisis response system is modeled after the CAHOOTS program in Oregon with a 35 plus year successful track record. CCIT NYC is advocating for New York City to contract with community-based organizations to establish mental health crisis

response teams that consist of one counselor who is appear has extensive training in de-escalation and one AMT technician who is not an employee of the New York City Bureau of the Medical Emergency Services because they deal with the cops - police, sorry.

The core characteristics of the CCIT NYC proposals are non-police, non-coercive teams that are default response to all mental health and substance use crises. We need community-based members and it should operate 24/7. The response time we would like it to be comparable to the response time of the -- and other emergency matters. (Indiscernible) leadership with peers, peers help a lot. Peers have gone through this already. They know what it takes to get forward, move forward, and they'll feel better, you know, whatever wherever place they would like to go. So, peers hired from effective communities on every crisis response team and in program leadership and on the oversight board.

Follow-up here connecting recipients to voluntary services that includes housing and support -- social support systems like they were talking about today, crisis respites, and the

version centers. We need transparency and that should be our evaluations to collect and analyze data regarding long term outcomes including housing availability, completion of treatment programs, and the avoidance of future hospitalizations.

Partnerships with community organizations and mental health advocates already working in space and uses 9-8-8 which will be activated in New York by July 16, 2022 as a calling number. In place of the police operated 911 system. A police response to a mental health crisis can be deadly. In the last seven years in New York, 19 individuals were shot and killed by police responding to mental health crisis calls. It's the 21st century and we need to look at the proven and cost-effective alternatives to psychiatric hospitalizations including mobile crisis teams, crisis stabilization centers and living rooms.

The goal is to help people in crisis gain control of their symptoms while remaining in their community. If we do not develop the alternative response systems such as the one proposed by CCIT NYC we will continue to see

theft, and abusive treatment of innocent people experiencing a mental health crisis. Thank you.

LETITA JAMES: Thank you for your testimony. You're right. Alternative response systems obviously is a model that we should support, provide resources, and the models are out there. And so I thank you for your testimony and I apologize that you had to experience that unfortunate forced hospitalization. Thank you ma'am.

ABISOLE FATADE: Last but not least, (indiscernible). Please move the microphone closer to you.

TAYA NEWITT: Hello, my name is Taya Newitt. I suffer from PTSD and depression and my mental health interaction -- I saw you on TV and I -- when I saw this I contact you guys because I tried to get help with resources and for my treatment because I was -- I was approved and established for PTSD and depression. And even though I was approved and the judge approved it and my doctor prescribed medications for me. The carrier commits fraud.

The carrier for workers comp, they commit a lot of fraud against mental health work

-- mental health injured workers. And I've been trying to get help. I have wrote the governor. I got no response -- actually, they transferred me back to the (indiscernible) for the workers comp that don't even answer my call. They -- I spoke to them once in the last four years and my attorney actually commit fraud, tell me to lie to the judge in court outside court and I told the judge, said this attorney right here next to me tell me to lie to you that don't -- you told the judge -- you told the carrier to get to independent medical stuff and they only got one.

And so therefore, you know, it had legal have legal consequence and they don't help me. They don't help me. They -- I complain every day. No one wrote me back. No one answer me, I never complained to your office. Now, I just understand that you are doing this. So, I'm going to send you guys a bunch of all the old e-mail.

I contact my congressman. He says that he don't deal with federal he only deal with state. But there's a lot of fraud with the insurance carrier in workers comp. I told the commissioner, I told the vice commissioner, I

told the office of general counsel, I have not received not even an e-mail back from none of those office and every day I'm going to keep complaining until God come and they try threatening me.

Joe from the office of general counsel who's in charge of -- who's the head of the ombudsman, he said Mr. Newitt, you know, they're going to come after you. This is what he said to me, you know, they're going to come after you, they're going to get at you, you -- what you're doing, they're going to come – I tell them and I report it all the time and I wrote in a letter said Joe told me that these people going to come after me and they put in -- and in court they even said, oh, we're going to muddy the water.

We -- that's what these people said in their officer of the court. There's a lot of fraud and I've been telling you guys and I'm going to always say there's a lot of fraud with work -- with injured workers getting help and even when you gain approval and when -- even when you gain approval they still don't help you.

They chop up my medication, my medication was stopped then go -- even though it

was approved, the carrier paid then they don't pay two months and then they -- then you have to go to the judge and then the judge make them pay. So, they do this intentionally. Even though they know that they must -- it's already established and they're supposed to pay.

Some of these medications I'm not even supposed to stop without it -- the -- my psychiatrist who I see once a month and my psychologist who I see every week they tell me these drugs you have to come off of it slow. So, when they stop me from getting these drugs -- these medications instantly -- just suddenly it bothers me because that -- these drugs and this is what they do all the time.

And I complain. Today I had court actually at 3 p.m. In that office back there and I told them, you know, that -- the judge I order -- I filed a report to get the audio and I heard the judge and the carrier talking about my case before I even came to the courtroom and they were the only two in there and I wrote this up to the office of general counsel. I wrote this up to the judge supervisor. I have no response, no response. And the one time they respond to me

they said mister, you were right but you had an attorney.

Now I fired attorney when he told me to lie to the judge. Attorney told me to lie to the judge and I told the judge. Judge, this attorney told me to lie to you. Nothing happened to the judge. Yes. They gave me everything that was supposed to give in to me.

But the action -- what if I listened to the attorney? What if I had listened to -- because my common sense tell me, said no, if the judge said to and you gave -- and you're telling me, don't let the judge know that they did not do it -- (indiscernible) independent medical report on my psychologist. That don't make sense as you as my attorney telling me that. And this is what -- this is happened in court on record.

So, I have audio and the court minutes of all these conversations and secondly the judge is so disrespectful. A lot of times they told me -- she actually told me shut up. The judge told me shut up. I wrote up her supervisor, I wrote up her and a supervisor wrote me back and said she was wrong, on paper because she told me to shut up.

I wrote the -- I wrote everybody every time and they don't -- there's no response. And that's why I'm here. When I saw that, you know, my issue is that, yes, you know, we get -- there is resources even when you're approved for resources, you still don't get the treatment. When you're black, there's a second-tier treatment compared to when you're white.

Even the people who work for you, these people, they treat us different. They don't treat us the same when you call your office. I spoke to the some of these congressmen and the congressman is one way and the people who work for him is another way. They and -- people see this, I'm not going to lie and act like I don't see it, I see it. These people -- so I appreciate but there's a lot of fraud in workers comp and there's a lot of fraud with the judge and the carrier working hand in hand together and I have been complaining and no one responds to me, no one.

And they just they just keep giving me what I want but they're not taking care of the issue because it's not like I don't get what I'm

supposed to get, they make sure I get what I'm supposed to get. You know, and you know they passed new rules. The funny thing, they passed new rules started May 2nd, my doctor who do the neurologist, the head concussion neurologist examination that the judge ordered them to do every -- twice a week. She told me last week that because the new rule came out, she cannot longer be my doctor for that department.

So, I only have now just a psychologist and a psychiatrist. But the neurologist, the neuropsychologist who does that test, she doesn't -- she says that she can't do it no more because they're not paying her the same like how they used to. So, now I never heard of this now in the middle of treatment.

I (indiscernible) injured worker and I have to go look for another neurologist and that can cause a problem with my workers comp because if there's not a doctor within the next six months that come and put in some paperwork regarding that, that the carrier could just say, oh, that's like dead issue going underneath the rug and this is how they use the process to manipulate and target poor people.

And it's not, this is not the first time I would say this. There's a lot of racism with mental health, extremely racism in mental health that I (indiscernible) Orlando you would experience, that's what I'm telling you guys. I experience a lot of racism with workers comp, the -- and the carrier. Mostly the carrier and sometimes your attorney like in my case, the attorneys working against you.

As when my doctor told me these decisions. Mr. Newitt is they make decisions on the (indiscernible) not in the court and I find that very disappointed and I refuse to live in New York state. That requires me to be treated that way. That's why I appreciate you and I thank you are the people lawyer and I really appreciate you for listening to me and it makes me feel better. Thank you.

LETITA JAMES: Thank you, Mr. Newitt. If you have any information, if you want to submit to our office, we would appreciate it. Thank you for being here and thank you for testifying. I truly appreciate it. And I want to also thank Ms. Graham-Nyaasi, did I say it right? Thank you for your testimony and again I

apologize for your forced hospitalization, but I really want to look at the Oregon model. And thank you for your recommendations. And Mr. Colavito, I look forward to seeing you in Sullivan County and you telling me more about the SALT program.

I thank you all. So, at the top of this -- yes ma'am.

EVELYN GRAHAM-NYAASI: The CAHOOTS model -

LETITA JAMES: Yes, ma'am.

EVELYN GRAHAM-NYAASI: -- they've been in operation, last year they had 24,000 calls to their center. Only 150 of those calls were answered by the police. And they don't carry weapons and no one has ever been killed or injured.

LETITA JAMES: Thank you, we're going to examine that model. I appreciate you all and thank you for your testimony. And so this -- at the top of this hearing, I said that instead of a dark abyss, we need a supportive safety net of care. We heard from 28 individuals in person today and dozens more who sent in their testimony from advocates, to providers, to New Yorkers

living with mental illness. They all painted a clear picture of the state of health care in New York. State of mental health care in New York and how we can begin to have lasting transformative change. There are a number of individuals who submitted recommendations. We will review them as well. We heard many perspectives and issues that my office will follow up in the coming weeks and months.

And again, we will have additional hearings throughout the state. We heard from Tony Carino, director of psychiatry and (indiscernible) medical care NCUCS. He walked us through intersectionality of mental care and other health and social crisis like homelessness and the criminal justice system.

We heard from Ron Richter, the CEO of JCCA who said that a systemic refusal and cumulative neglect by hospitals for psychiatric care, especially for children. He's seeing that over and over again and Council Member Lee who identified the need for bilingual mental health providers. And we've heard in great detail how our children living with mental illness aren't able to get the care they need with Alice Bufkin

saying that the children's system has been starved.

We also heard from potential -- we also heard about potential violations, federal emergency medical treatment, and Labor Act or EMTALA as well as violations of parity laws, which requires anyone to be anyone coming to an emergency department to be stabilized and treated regardless of their insurance status or their ability to care.

My office will be looking into this issue and I encourage anyone who has been denied treatment or feels like they were not treated appropriately to contact my office by visiting ag.dot.ny.gov, that's ag.ny.gov. The link to submit your comments is on the web page on the home page. And also there should be a telephone number there as well, because I know individuals do not have access to the internet.

A lot of what we heard today was devastating, disturbing. My team is already looking at possible areas of reform. We will review each and every word of testimony and use them to inform our issues moving forward because this hearing was not simply about listening, it

was about listening in order to take action and informing my office for future investigations into allegations of inadequate mental health treatment.

Individuals deserve answers and I will do everything in my power to make sure that they get them, but please understand that this is just not a one off. We will continue to follow up. We will continue to reach out and make sure that individuals voices are heard and that individuals understand that at this point in New York state mental health care, we're at a crisis point and we certainly need action.

I thank members of the team, I thank the Office of Attorney General for doing an absolutely fabulous job. And this concludes the hearing and I thank you all for tuning in. Thank you so much.

C E R T I F I C A T I O N

I, Sonya Ledanski Hyde, certify that the foregoing transcript is a true and accurate record of the proceedings.

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Date: July 19, 2022

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