OAG Hearing on Mental Health Access in New York State

Submitted Written Testimony

Susan Klemme / Albany, New York

It is exhausting trying to find access to quality mental health care on Long Island. When you do not have the luxury of paying out of pocket and must go through your insurance, you are left with a very limited number of providers who have long waiting lists. If a provider you were seeing and developed a rapport with-which is essential for mental health treatment-stops taking your insurance, you are stuck of paying out of pocket or starting over at a new provider. Even with insurance, psychiatric medication is expensive and it can be difficult to obtain some medications through insurance. There are not enough providers for the amount of care that is needed, and many do not take insurance. We need a Medicare for all universal insurance coverage to simplify the process for providers and consumers alike. This current system is not sustainable. Non-profit service providers who provide mental health care are completely underfunded, which leads to low salaries and high turnover for staff, who are more often than not providing essential mental health services for those who need it most. We need more access to crisis and follow up care, without all the loopholes that insurance creates.

Erin Galante / Kings Park, New York

Mental health challenges are a real issue, and plague more American citizens than ever before. There are many reasons for this, but one of the major ones is the lack of proper age control on social media. Currently companies say they "restrict" it to age 13, but there is no control besides asking a question that anybody can just click no and input whatever date they want. This leads to minors having access to content that isn't appropriate for them and can lead them down some very dangerous roads. Further there are "controls" on social media that maybe were created with good intentions, but end up doing far more harm. Some of these controls are what's known as "restricting" or "shadow muting" users that the content creator doesn't want to interact with other people on that specific page, video, comment, picture etc. What this looks like to the person who is "restricted" is that nobody is interacting with their comment. This person is never told they are restricted, or shadow muted and instead are left to wonder if it's the formulation of their comment, the content of their comment or that it must be something about them personally. Understand there is no face-to-face interaction where normal communication could settle the underlying issue that led to that person getting restricted in the first place. This happens every day to millions of American citizens and definitely to the great citizens of New York State. There is another rampant issue with social media and that is the use of "bots" or automation to post content, post comments, regulate

comments, and other actions. This leads to users trying to "interact" with these comments, pictures and other content. The problem is that once again they have no idea there won't ever be a response because a machine is doing the work. This results in a person getting flooded with thoughts that they are doing something wrong because there is never a response. Finally, there is no mandated reporting of threats made on social media to law enforcement. There is a lot of harassment, bullying and violent threats made every day on all platforms of social media. These never make it to LE unless the reports are very over the top, which results in once again no correction of behavior to the user making the threats. The person who is getting abused has no relief other than to try to block/delete/restrict the person, but the abuser is never challenged in real life. Imagine growing up where all of your interaction has only been through a computer screen and not face to face like the majority of adults now had growing up. Imagine coming home every day and going right to the computer instead of going to cause a little ruckus with your friends around the neighborhood. These are problems that are contributing heavily to the mental health issue not only in the USA but specifically in the great state of New York. Social media has a place, purpose and can be a great tool, but it has done a great deal of damage in the short term to people's psyche. Regulating the age to use social media to 18, banning the use of "restricting or shadow muting" and forcing social media companies to report all threats made on the platform will help combat mental health issues significantly. This also will help the State prevent some other related incidents such as firearm violence because some of the underlying issues are mental health problems

Matthew Deinhardt / Binghamton, New York

I have scheduled several doctor appointments. The first issue I am having is my automobile was unlawfully seized. I was a victim of a crime committed against me. It was my private property and personal transportation. It has been since last year Father's Day since I had my car. I need it for private transport. This has affected me mentally and physically since I have a personal injury and am not working, furthermore, I cannot walk everywhere or afford public transportation while private transportation was more affordable and convenient. I cannot afford a lawyer, no other lawyers will accept my case while I have been having difficulties with litigation and filing my paperwork on my own. The court has been delaying my case and making errors on behalf of the attorney at the appellate division in Rochester which has clearly been obstructing my case. I have been facing continued harassment from the police and have had several incidents in the past. I have set up doctor appointments and have done as much online as possible but need a Xray done in order to receive disability. They refuse to allow me to come in because I refuse to wear a mask due to anxiety I get immediately, and the masks provided were never individually wrapped and while breathing through them I was tasting a chemical that was making my lungs irritated. i have been refused service of any kind.

Christopher Day / Staten Island, New York

I had a mental health episode about seven months ago and have since been in treatment. In terms of access I would like to say that when I arrived at the hospital, I was experiencing paranoia, and this caused me to want to record. The hospital staff had me thrown out because I was violating their rules against recording, which aggravated my condition and caused me to be involuntarily committed. Succinctly, when we discuss accessibility, we must discuss the treatment of patients that come into the system. It is a system so afraid of criticism that it would rather turn away someone in need than face being recorded. It is a system that, in my experience, bloats itself with non-emergency "emergencies." Had anyone simply explained to me that I was exhibiting psychosis symptoms, I believe I would've had the ability to stabilize on medicine in the comfort of my home and not the confines of a psychiatric ward. Instead, I feel the doctors did their best to dance around telling me what they were thinking. I was not a patient and we were not working together for my health, they were trying to manage me, and that feeling of being managed made it harder to trust doctors in my most vulnerable moment.

Again, if we want to be serious about mental health, we want to reach a point where we educate people that arrive at hospitals in need of help. We want to create an atmosphere of warmth, healing, and connection. If that comes from more scholarships for doctors, so be it. If it comes from a re-examining of hospital rules where a patient's condition might be causing violations, so be it. All options need to be on the table.

Healthcare is inaccessible and incomprehensible as it is, with my insurance sending me EOBs stating I owe nothing while the hospital sends me bills for hundreds of dollars. Please consider my experience and consider crafting rules that ensure that when patients show up at hospitals, they are not turned away and that their mental health moment doesn't become a crisis requiring hospitalization. Please consider crafting rules that simplify a system that does not require so much complexity. Please consider committing to public awareness campaigns that de-stigmatize mental health issues and encourage people that experience changes in mood, thought, or behavior to seek help.

As an aside, please also take note of the work of Take Medicine Back and Dr. Mitchell Li. My understanding is that across the country emergency rooms are being understaffed under the guise of shortage. In reality, corporate greed causes this chronic understaffing and likely adds strain to the overall system. We must take measures to ensure this is not occurring in New York.

I share my experience publicly in the hopes that we can have a better New York and that fewer people will have the experience I had.

Carrie Mitchell / Penn Yan, New York

My name is Carrie Mitchell and I am a licensed clinical social worker that has worked in the mental health field for the last 15 years. I have had the opportunity to work with children, adults, and currently our veteran population. I have seen our mental health system deteriorate before my eyes in my small town of Penn Yan, NY. At one time we had a inpatient unit and several outpatient clinics to provide the "step down care" patients need post hospitalization. The inpatient setting and the outpatient clinics no longer exist. We know that one of the leading causes of death amongst teenagers is suicide; however, we have done nothing to try and change this statistic. We have not increased therapeutic supports in school systems, we have actually removed the funding for those services. Accessing mental health treatment for both children and adults is at least a 4-6 month wait and the drive times are 40-60 minutes if the provider or patient is unwilling or incapable of doing telehealth. I am a huge proponent for least restrictive settings; however, I believe shutting down the majority of inpatient psychiatric inpatient facilities was extreme, dangerous and left a population of severally mentally ill people without the care that is needed at times. I am thankful that this mental health crisis is being looked at and hopeful for future change.

Laura Giunta / Levittown, New York

Syosset Hospital's psych unit has been closed for over 2 years now due to Covid, denying our mental health community of much needed psych beds. Often times psych patients are sitting in the ER for DAYS waiting for an available psych bed or are just turned away rather than getting the help they need. Psych patients are sometimes placed on med units which is not conducive to their treatment needs, and puts additional strain on already understaffed, overworked nurses and CNAs who aren't equipped to handle psych care. Mental health has only gotten worse while resources have diminished since the start of the pandemic.

Jessica Robinson / Buffalo, New York

My name is Jessica Robinson. I recently had to take my older sister for a medical hold at ECMC for paranoid schizophrenia. ECMC was world class but their ability to treat is so limited. She was released after they adjusted her meds because they legally would not be able to win a hearing to keep her longer. We were hoping to get her into mental health housing after her hospital stay but it is incredibly hard to get access to. We were told they currently have 2 year long waiting lists. We finally had gotten my sister to a place where she was willing to live in a facility that offers on-site supervision of medications but when she was told it would be such a long wait, she went back to her apartment in the Bronx. We haven't heard from her since.

I don't see why we can't create more mental health housing facilities. The demand is there. Many people already receive enough disability to fully fund their rent and fees for such a facility. We need to make sure our mentally ill are in safe housing where they can't be taken advantage of and can get the help they need. Outpatient care is not enough for those with schizophrenia and a myriad of other disorders. There's no guarantee that she will keep up her care for schizophrenia. She has paranoid delusions that she'll have for the rest of her life according to her doctors. The best they can hope to do is keep her in a good state of mind. Our question is what happens the next time she starts spiraling? What if she does become a threat? She keeps to herself mostly so there would be no warning. This is the challenge our nation faces.

There is such a great need of people that want to ensure their loved ones are living with even just some minimal supervision so we know they're ok. Many people ask why we don't do it ourselves. Often part of delusions include family members—the number of times she has made accusations against my other sister to me or vice versa I can no longer count. She's cut off all communication with my father's side of the family. There's always an enemy. Also, the courts won't let you take legal guardianship unless they are deemed a harm to themselves or others, which basically equates to will they commit suicide or harm someone else. We're letting people walk around not being able to take care of themselves for the sake of autonomy.

We went 4 years prior to this without knowing if my sister was dead or alive. Imagine that. The only way we found out she was alive was that she randomly showed up on our doorstep one day this spring. She was clearly in distress and had paid someone $1k to drive her from NYC to Buffalo. Who's to say she won't go off her meds again? Or end up with insomnia to the point that it deems her meds ineffective? When living on her own we know she wasn't feeding herself properly. We know her condition is exacerbated when she is not eating well. She has no one looking out for her except a doctor that sees her on an outpatient basis every 3 months but there's no guarantee that anyone would check on her if she doesn't show up to those appointments.

I beg of this team. Please do all you can to get people viable long term treatment options before it's too late. A constant cycle of hospitalization, discharge, outpatient, off the wagon, then back to hospitalization benefits no one and it's not effective. We need to provide our mental health professionals with effective long term treatment options available to all. We know the tie that mental health has to violence. We know that ignored mental health issues can lead to violence. We need to make treatment available to those already diagnosed and make barriers to entry level mental health care a priority.

I'd suggest we start with mental healthcare housing. It also would have a positive impact on the homeless population not discharging them back to shelters.

Annemarie Uliasz / Brooklyn, New York

Our family struggled for over a year during the pandemic to obtain the appropriate evaluation of our elementary school child who was eventually diagnosed with ADHD. Because of limited mental health care providers who are preferred by our insurance, we had to use an out-of-network provider and must submit paid invoices to our insurance. We will not receive any form of insurance coverage until we meet an individual deductible of $10k (after we meet this deductible, only 50% of covered care will be provided). This is excessively expensive for vital care that our child needs in order to function within the school and home setting.

Jeremy Klachkin / Brooklyn, New York

I am a social worker and therapist. Before working at the current private group practice providing mental health to adults and teens, I was working within a children's mobile crisis team throughout Brooklyn. I loved that job, and I loved being able to divert mental health crisis away from police involvement and towards direct mental health care. The biggest obstacle to staying at that job was the uncertainty provided to us by Dohm and doe. Our hours were changed with little notice, increasing burnout without involving feedback from the people doing the work on the ground. We did have weekly check

ins, but when big changes occurred the lip service stopped, we all feared for our livelihoods, and complied. We were forced to expand providing care to up to 20-year old's, when everyone signed up to providing care to children. Many changes were instant and seemed to be done by bureaucrats who did not care about a work/life balance. This mentality trickled down to directors and supervisors and lead to good, smart people leaving before they had planned to do so. All of this, with few inpatient options available, and long wait lists to gain outpatient care. Those external factors did not seem to matter, and protocols and mandates set before the pandemic were expected to remain intact. It is a shame and shows how little the city cares to sustain programs doing work to divert young people away from direct police involvement. I left in order to gain a better work life balance for my family and support system who were directly impacted by the consistent lack of systemic care.

Tyan Hewitt / Bronx, New York

As a person that suffer from mental health(ptsd, depression) in New York, I have difficulty finding resources and when so, they tend to fail me too... mental health and dealing with Worker comp creator more difficult for mental health workers.... some peoples take advantage of me while trying to get medication and therapy treatment....

Brady Berman / Astoria, New York

I have been working in inpatient psychiatric care for nearly 15 years at this point, through grad school and as a professional clinician. I have worked in city hospitals, private hospitals, non-profit hospitals, and state hospitals. I have watched as, little by little, inpatient psychiatric care has slipped away in the state. Between Kennedy and Reagan, and the deinstitutionalization movement from the 60s-80s, more than half of all inpatient beds have disappeared. From 1960 to 2020, we are up to 90% of beds lost in NY. Much of this has been a combination of three factors - the dedicated work of NY governors, especially Cuomo, to reduce the state budget and investment in inpatient psychiatric treatment, leading to the reduction of beds in many hospitals and the outright closure of others, including Middletown Psychiatric, Kings Park Psychiatric, and Hudson River Psychiatric. Mayors, especially Giuliani, Bloomberg, and DeBlasio, closed many local hospitals that provided acute inpatient psychiatric care (28 by my count since 2000), turning that land over to luxury development. The medical value of these hospitals was acutely felt during 2020, when psych patients in HHC hospitals such as Bellevue were turned out in order to make room for Covid patients. Finally, private hospital systems such as Sinai and Northwell, as they consolidated, chose to remove many of their inpatient psychiatric facilities, as treating such patients was a financial loss for them. This leaves NY with thousands fewer inpatient beds in the state compared to even twenty years ago, and NYC with only municipal hospitals equipped for inpatient care.

One example - my current facility used to be multiple acres, tens of buildings, with a population of 3,000 patients at its peak. It is now two inpatient buildings serving 350 or so patients. The other buildings were demolished and leased out, now serving as a server farm for a banking corporation.

The promise was to replace these lost beds with community treatment. While some supportive housing was built, the difference in those needing those beds (most of which are serviced by third parties, with a not insubstantial abuse of Medicaid funds in some cases) and those able to get those beds is insurmountable. The largest hurdle in discharging an inpatient back to the community is not achieving psychiatric stability, but in finding a bed for them. Waits for supportive community beds can stretch years, making a 7-month inpatient stay a three-year inpatient stay. To boot, patients with a history of contact with the justice system (e.g., the vast majority of inpatients, and especially people of color) face discrimination in preference for those beds, as third-party organizations running supportive housing prefer individuals coming from 28-day rehab, or a middle-class background.

To add to the discriminatory nature of acquiring a bed in the community, local opposition to building community facilities (largely due to stigma) have resulted in a ghettoization of community housing for psychiatric patients in a number of small neighborhoods, at least in the city; particularly in Harlem, Flatbush, the South Bronx, etc. The effect such a concentration

of beds in those communities has had is evident, to say the least. A cycle is therefore created where patients are only surrounded by the neighborhoods created for them, and when the inevitable lack of support leads to a relapse, they end up where there are beds available - jail or prison. Sometimes for years before they are civilly committed to a hospital, where they will spend years waiting for a community bed to become available. There are more mentally ill individuals in shelters and carceral facilities than there are in inpatient or community beds, by double, triple, or a factor of ten in some areas.

When inpatient beds became so concentrated and geographically isolated, and with civil service levels of pay, many psychologists and psychiatrists (who have been pushed out of local hospitals when they left the mental health business, in favor of extreme and palliative short-term care by nurse practitioners and social workers) have chosen not to train or work in the inpatient setting. These are workers that are likely to never return, no matter what investment in inpatient care is made. Instead, the state pays contract psychiatrists 3x the civil service rate on a regular basis, costing the state far more than it would have if it had invested in more beds in more geographically accessible settings, making them more desirable. Most community supportive housing have no psychiatrists or psychologists at all.

The nation, the state, and municipalities have decided since 1960 and accelerated since 2000 that they do not want to be in the business of public mental health care. The result is the incarceration of tens of thousands of mentally ill each year, and an astronomic increase in the homeless rate, exacerbated by the lack of supportive housing, or even affordable rents for those stable enough to be living on their own.

Even if the federal, state, and city governments completely reverse course and endeavor to restore humane and therapeutic inpatient service for the mentally ill, as well as supportive and community-based housing for outpatients, and that investment starts with doubling all funding to OMH, OPWDD, OASAS, and Medicare/Medicaid reimbursement for outpatient treatment, as well as doubling the rate of construction of community supportive housing, it will take the same amount of time to restore as it did to tear down. Sixty years.

Arlene Gonzalez / Maspeth, New York

My son is 39 years old and continuously disappears from us in NYC. He was born and bred in NYC. He left for the army; he signed up for a 6-year contract, and when we found him again, he was mentally unwell, we think he was discharged from a base in Utah. His father, sister and I, mother, all live in NYC. He sometimes appears at his dad's home in Brooklyn looking very unwell emotionally and physically. We've tried to get him to a doctor, hospital, veterans administration hospital, to feed him, have made calls, but have not been successful because after a time, a few days, a week or a few weeks, he will disappear again for months.

Devon Gallegos / Brooklyn, New York

For years, I have done grassroots harm reduction work out of pocket in various drug use communities in NYC, and for my day job, I used to provide administrative support to a team of peers. That job saved my life, and I will always appreciate them, but I fear my former colleagues and probably much of the mental health industry in this nation is setting themselves up for failure because of an entrenched need to manufacture the perception that they can handle overwhelming workloads.

I have seen this amongst various vulnerable communities. A resignation that the employer is not going to change or listen to staff, or that staff cannot make a difference in the grand scheme because they are who they are and this is how it has been. So they will say yes to workloads that grind them down. They will say yes even though stacked traumas seriously lower the stress threshold, diminish working memory, and cause symptoms to return, and relapses to happen without being framed as opportunities.

But everyone must abide by the contracts, and make their monthly numbers, even though they keep losing people at home, or have had to be a mother to a kid with no parents, or in a household whose abuse has ramped up for pandemic. What use are the numbers anyway since they only measure how many people show up at the door whereas actual useful metrics like quality of life improvement in a home happen across years and can't fit inside any progress report.

And are community mental health agencies viewing the mental health of staff with the caring eye they give their clients, or are they like those pillars of community with a public face who save the cruelty for their kids and spouses? Yeah, everyone has been through trauma, suck it up! Oh my childhood was worse, I call this Tuesday! See you next time!

Does the staff of a community mental health agency truly support each other through this unique time of strife that isn't over, or are they performing the surface niceties that make new hires comfortable to share the personal info they can later use to voice concerns to HR, who is one-person working half time for the dozens of staff suffering in unique ways, silently, to keep their jobs?

We were warned about the increased privatization in health care in NYC, and members of DHOMH with financial interests in the privatization of mental health. So gotta keep up those numbers, or else DOHMH is gonna find reasons to pull funding for peer support, even though the White House acknowledges the essential need of peer support, which is the simple act of having a listening ear and acknowledging a person's unique journey through life where even hearing voices and seeing visions is well inside the spectrum of normal human experience, but we as a people still think that's the mark of crazy.

No, crazy is thinking "why fund peer support? you can't patent a listening ear!"

There is no crazy, just the thousand and one faces of interpersonal, emotional, physical, institutional, and historical trauma. Throw the DSM away and write the word trauma on a post-it and glue it to the monitor at work, but before you get to your workspace, I have to take your temperature with this thermometer that only measures the surface of the skin, which isn't a reflection of the body's heat, which if 100 degrees or more, means you should go home, but what good does that do in containing a virus that transmits asymptomatically for most people?

These unnecessary pressures combined with performing safety theaters, while sensing the disconnect between the kindness of your colleague's face with the actions of their body. Actions which you know is survival, you get that, but you cannot stop being a victim to it because of the corruptions embedded into a century of drug war fueled with lies and overstatements of harm, which is the creamy center of the larger truffle of slavery--you don't need pigs to sniff that out! It is self-evident nowadays, but no worries, we will try to forget shortly so that we can go back to normal, just with emptier pantry shelves.

You have us apply for new contracts to join teams of mental health colleagues to do outreach, and as we apply we learn the mayor and the governor has already sent teams of cops and mental health workers to the subway ahead of us. Did the homelessness advocates tell you that the middle of winter is the perfect time to oust the homeless from the warm subways? That doesn't sound like homeless advocacy. That sounds like someone who has just bought new homeless shelters to fill, because only the entrepreneurs would do something that stupid.

Sending the police first for a mental health issue, it is no wonder why that fellow shot up the train station at Sunset Park. Remember that he called those doing outreach to the homeless "homosexual perverts"? Do the math, and he was a teenager in the 1970s, when mental health clinicians who were homosexual also had to be closeted about it, because homosexuality was a mental disorder. Now imagine this kid, who probably had enough problems with adults taking advantage, gets paired with clinicians who have spent a life having to read the coded language we closeted queens had to employ to flirt and survive. Imagine that clinician performing a disastrous misread, and the kid, used to the abuse by now, just accepting it, and filing the experience for later.

Random acts of violence, my ass. Murders do not happen in a vacuum. Violence does not happen in a vacuum--the provocation happens earlier than any of us know or witness.

You want to truly make a dent in the mental health crisis. Do this immediately:

» End the Drug War - the gateway drug is the abuse we do not talk about that permeates this culture, and drugs are the rational ways of coping that criminalization makes deadly. Criminalization is the most harmful harm about drugs. The dark side of meth is America. I should know as an active user of it. I am in recovery, and the stimulants I have used in recovery enabled me to identify the patterns of harm in those I once trusted who used my cognitive blind spots against me, and it gave my ADHD brain the wherewithal to leave an abusive household. I know firsthand that stigma, and the ONLY time I have felt like an addict was when those I loved and trusted saw me as one, because they trusted false media over the lived experience of the person in front of them. You know what has calmed many folks overamping on stimulants? A listening ear. Stigma is the one that's doing the killing, not the drugs. You want to be anti-racist? Doing this will prove you all have skin in the game.

» Housing - You want to keep people safe? Keep them housed. When people know they have housing, then all their alternative selves - the ones that have had to be wily and willing to cut people to survive, can calm and start hibernating, letting the better selves take the wheel. But as long as there is a group shelter where one has to keep one eye open to keep their stuff, or put on their dead man self in order to be in a shelter with other men without getting raped, then you are gonna have crime. You are gonna have folks lily padding from place to place for the drugs to keep them awake so that they can still protect their stuff. The human body needs a place they know is safe, who make nooks and crannies in neighborhoods where rich white folk just don't want to deal and ignore, which enables a cycle of sleep to happen. Sleep is required for the body to START to heal. There's no sleep, there's no healing.

» Acknowledge Mistakes - state your limitations, for that is not weakness. Not being able to say that one is wrong, that one makes mistakes, begins the vast chain of deceptions that lead to cascades of disaster. Pandemic, anyone? Whole human corporations and movements are hobbled by the vast amounts of investigative work to suss out systemic lies due to ego. Not ego, due to a disability that needs to be acknowledged as a disability under the ADA, one that prevents folk with the disability of theory of mind from having leadership and financial positions until they have performed enough mindfulness work to create the structures in their medial pre-frontal cortex to imagine the capacities of their colleagues. Until then, put them in outreach, or in positions where they have to get people excited about things. Make them a staff of one, give them a domain that feels like a sufficient domain to lord over, but no one under them who can be harmed by that dynamic. This disability doesn't mean they cannot work, cannot be contributors to society, but we have to do the work to understand the early injuries that makes it challenging to consider others, hard to act in good faith when there were bad actors in their lives before they had personhood. This is a difference that is older than human history, and one that the Golden Rule addresses. Even God had to fool folk into kindness. We need to figure out reasonable accommodation for this difference that is central to a lot of the mental health issues we are experiencing, and capitalism ain't helping things.

These issues will not be fixed in any way that will improve election prospects. Morality is to serve the greater good, even when no one is looking, and certainly when no one can vote about it. Deal.

Lisa Giunta-Popeil / Farmingdale, New York

It is my understanding that the psychiatric unit at Syosset Hospital has been closed for over two years, since the beginning of Covid. The fact that people in mental health crisis have allegedly been turned away at Syosset or allegedly don't have the option to be treated in a psychiatric unit when admitted there is unacceptable. There are so few beds on Long Island for mental health patients as it is, there is simply no excuse for Syosset keeping the psych unit closed for this long. We need definitive answers as to when the psych unit is going to reopen at Syosset Hospital.

Dawn Giunta-Carr / Port Jefferson, New York

The mental health crisis has long been an issue in New York; however, since the COVID-19 pandemic, it has only gotten worse as services and resources have diminished. Early in the pandemic hospital beds were needed for the huge influx of COVID patients, with inpatient psychiatric units being repurposed for such needs. Northwell Health's Syosset Hospital's inpatient psychiatric unit was one of the many.

To date, Syosset Hospital's psychiatric unit has been closed since April 7th, 2020, denying our mental health community of much needed psychiatric services and instead being used for storage of hospital beds, chairs, tables, various equipment, etc. The last time the unit was used for COVID-19 purposes was the summer of 2020.

On Long Island, many hospitals have seen the uptick in patients coming to the Emergency Department with mental health related issues, Syosset Hospital included. Often times psychiatric patients are waiting for days in the ED for an available psych bed or are just turned away due to lack of resources available. Sometimes these patients are admitted on to the medical units, which is not conducive to their mental health treatment needs and puts additional strain on already understaffed, overworked nurses and nursing assistants who aren't equipped to handle psychiatric care.

Syosset Hospital's psychiatric unit provided mental health services for northern Nassau County, including electroconvulsive therapy (ECT), one of only two Northwell facilities that offer that treatment option. Being a psychiatric unit in a medical hospital allowed for treatment of psychiatric patients with medical issues, a service that Zucker Hillside Hospital and South Oaks Hospital are unable to provide, making Syosset Hospital's psychiatric unit specialized in this area.

The psychiatric unit at Syosset Hospital is still considered a temporary closure due to COVID. However, after over two years, can it still be defined as temporary? This 20-bed unit remains empty; its only purpose is serving as a storage unit. How much longer will our mental health community be denied much needed services? This hearing is about our mental health community and how we can improve services, outreach, and resources. Let's start with putting back the services that were taken away.

Martin Colavito / Liberty, New York

My name is Martin Colavito, and I am a resident of Sulivan County New York. I am part of a grassroots Community Coalition named Sullivan Allies Leading Together (SALT). SALT is comprised of community members and "Boots on the Ground" Human Service providers. I am a community organizer and have treated those suffering from substance use disorders for approximately 30 years until I chose to let my credentials expire due to a paradigm shift in regard to community care.

SALT is a diverse partnership of agencies and community resources committed to improve the quality of life for the residents of Sullivan County NY.

Through information sharing, increased prevention efforts, and interagency collaboration, we seek to improve access to services that empower members of our community to make lasting and productive change.

Even before COVID, access to Mental Health services in Sullivan County had been a challenge at best, and nonexistent for many, at worst.

As a Community Coalition, SALT members are an integral part of many efforts that are trying to address the current Mental Health crisis that is affecting our County.

For over a year we have been a part of the Police Reform efforts and continue to meet with local Departments in regard to law enforcement and community collaborations. A consistent thread in these conversations is that police are constantly being in the position to address Mental Health crisis because there are simply not enough resources to address those who are suffering 24 hours a day, seven days a week with disabling mental health issues.

Currently, Mobile Mental health response times are simply unacceptable, and are not available consistently during evenings when many Mental Health episodes occur.,

Our county resources are compromised by the lack of available Mental Health/Substance Use Disorder professionals who regularly leave our county for better wages in surrounding counties. This exodus leaves Sullivan County's standards lower in regard to our community member's care.

As a community member and after the numerous acquisitions of qualitative data, I can tell you that many people have become accustomed to the lack of care concerning mental health disorders.

The constant narrative from clinicians is that there is incredible pressure to comply with satisfying the required billable units of service in order for agency funding to continue. As a result, this is leaving them hopeless and in many cases in severe need of wellness opportunities to cope with this situation.

I have personally witnessed people on hold for hours trying to arrange transportation to services so they can attend their Mental Health sessions. Many give up and have their conditions exasperated. This was the case before COVID and become exponentially worse since March of 2020.

From March 16, 2020, until now SALT members have been reaching out to those who are compromised due to mental health, substance use disorders, physical disabilities, and seniors in Sullivan County to enhance socialization, food security, and continue a human touch.

As a Community Coalition, part of SALT's mission is to navigate people to service. Unfortunately, those who are charged with doing so are under so much pressure that compassionate and consistent navigation to care is often missing due to the substandard working conditions that exist in Sullivan County.

I do believe in my heart that many the providers and the County itself are trying to do their best, but I fear that rural, impoverished, and unhealthy counties like Sullivan (Sullivan County is ranked 61 out of 62 by the Robert Wood Foundation County Health Ranking) are often overlooked because our low population. I attended a regional meeting with those charged with providing resources for physical and mental health disorders and was told that "There are not enough livable bodies in Sullivan to justify more resources". I will remember this response forever!

There are no Community Health Workers in our County to engage those in areas that because of their proximity limit access to care. Rural counties need folks to meet people where they are raher than expect them to overcome geographical obstacles to service.

I beg you to consider those in our county who are truly underserved and appreciate the opportunity to vent a little after the past few years of living hell!

Dawn Andolfi / Port Jefferson, New York

On March 13, 2020, my 10-year-old son was sent to CPEP at Stony Brook due to thoughts and a plan for self-harm. We had originally called DASH, which I understand was created to prevent visits to the ER, however, when we called, we were told they would only send him to the hospital anyway. For anyone who remembers, March 13, 2020, was the day the whole county went on lockdown due to the pandemic. One thing I learned that day was it is hard enough when your child has a mental health crisis; but it is another to have a mental health crisis in the middle of a pandemic. I quickly learned that for my son's age there were only two options for him should be admitted. Stony Brook or South Oaks. That day we were lucky enough to get him a bed at Stony Brook. He was admitted for one week and was rushed out because they were closing the unit to make room for COVID patients under the Governor's order. My son did not receive proper follow up care. He was asked to have a trust and bond with a social worker he had never met and would only do Telehealth appointments. Three months later we had to bring him back to CPEP where we were now told our ONLY option for inpatient care was South Oaks 45 minutes away from our house. He was in CPEP for nearly 48 hours because there were no beds. How can there only be ONE hospital available in Suffolk County that can treat our precious little ones? With no other option my 10-year-old was sent to South Oaks, and we were not allowed to visit due to COVID. We received no phone calls home because he didn't have to call if he did not want to. My 10-year-old son who went in naive and immature learned about oral sex and drug use from reading Anthony Bourdain fiction books that he was given access to. My son spent nearly a month at South Oaks without a visit from his family. Without proper group counseling with his family. My child was restrained, pumped with sedatives and over medicated. He was 10. He had been bullied for two years prior and was sad and no longer wanted to live in this world. He was treated like an animal. he was mixed with age groups that were inappropriate for him. And as a mother I was helpless. There were no other options. Two years later, the struggle to find competent mental health services is nearly impossible. The list of doctors that take insurance is short. They are overbooked and you wait months for an appointment. Most doctors won't return your phone call. These are our children. Intervention at the first signs of crisis should be accessible. It should not be traumatic. ONE HOSPITAL FOR ALL OF SUFFOLK COUNTY IS NOT ENOUGH. PLEASE DO BETTER.

Kristy Gulatto / Central Islip, New York

I am a behavioral health occupational therapist that works at Syosset hospital on their psychiatric unit, which has been "temporarily" closed to allow room for Covid patients since April 2020- two years ago. We only used the psych unit for a short time (maybe 3 months) to house dying covid patients. So, since some time in 2020, the unit has had NO patients on it at all.

I have written numerous times to Governor Mario Cuomo and now Governor Hochul, urging them to get involved in contacting Northwell about this unused unit. They forward my letters to OMH, who haven't really been of much help either. I have informed our behavioral health service line numerous times, via email, that there is an influx of psych patients who come to many of the Northwell emergency rooms seeking treatment, only to sit around for days because there are no inpatient psych beds available. That is ridiculous when we have a 21-bed unit sitting here UNUSED.

I have been a strong advocate for the psychiatric population, and I have a Syosset hospital petition to reopen our psych unit at Syosset hospital- gathering signatures from doctors, nurses, managers, therapists, social workers, dieticians, housekeeping, etc. Yet, our unit is still closed.

The mental health population is not going away. We need to STOP any further closures of psychiatric facilities across New York. Enough is enough! There is no reason our psych unit at Syosset hospital cannot reopen. We are one of the very few psych hospitals to offer ECT treatment, which is vital, and sometimes the only treatment that can help a depressed drug resistant person. We are one of the only psych-medical units that can accept patients that have both psychiatric and medical needs at the same time.

Right now, our psych population is not getting adequate services. Either they wait for days and days in the ER, or they end up on medical floors where the medical staff are not equipped to handle the psychiatric needs of the patient. It's very sad to see! It's even more sad to walk back into a "temporary closed" psych unit and see it being wasted as a storage unit.

I have fought and fought for the reopening of this unit. You are my very last chance of a ray of hope. I feel like no one cares or listens to anything I have to say. Will you listen? Will you help? We can't waste another minute ignoring this issue. HELP US REOPEN OUR PSYCH UNIT at SYOSSET HOSPITAL.

Gabriel Valles / Kingston, New York

I work as a Clinical Technician in the Psych ER at Health Alliance Hospital, Kingston. I'm also a delegate with my union 1199SEIU.

I appreciate the opportunity to talk about the challenges to access to mental health for people with serious mental illness.

I'd like to talk about the work I do, the patients we care for, the challenges we are facing, and what needs to change to improve care for these patients.

I've been a psych tech for over 6 years, first in an inpatient setting and now in the ER since the Cuomo Administration ordered our inpatient psych beds closed to prepare for COVID patients.

This work was a natural fit for me in some ways because my family has experienced a fair amount of mental health challenges, including myself. So, when a friend became a psych nurse and encouraged me to apply as a tech, it was not a difficult decision. I'd taken some college courses, but most of my training was on-the-job.

A normal day for an ER tech starts by reporting to the RN and outgoing techs to get an update on our current population. We find out who is potentially suicidal, who might be violent, and what the needs are for all the patients.

We take vitals, we talk people through what is happening, we draw blood, we help patients with meals, and make sure the rooms are clean. The work is a combination of both clinical and other skills. I like to say we do 5 different jobs – Psych tech, EKG tech, phlebotomist, unit clerk, housekeeping, and dietary.

For these 6 jobs I earn $17.45 an hour.

The patients we treat in the ER are typically brought in by the police and are generally experiencing some form of crisis. They can be psychotic, suicidal, violent, intoxicated, or Oded.

Prior to the pandemic, the ER would evaluate them, get them stabilized, and move them to inpatient treatment or try to connect them with outpatient services.

That all changed with the pandemic. Our hospital lost 60 psych inpatient beds and none of them have come back. Now the closest inpatient bed is 45 minutes away and others are nearly 2 hours away. It can be even further to find a bed for children.

Losing these beds has been horrible for the patients. 85% of the patients I used to see on a regular basis are gone and I have no idea where they are. I'm very worried about them because usually there is not a good ending for these people with severe mental health issues if they are not in some kind of treatment.

It also means patients are spending more time in the ER than they should. It used to be intake, stabilize, and move them on to treatment. Now people are stuck here for days waiting for a bed. We have 4 rooms with beds and 4 spaces in the hallway with psych stretchers and the conditions can be rough. We just are not set up to hold patients for longer periods.

We also lost a lot of good staff to this closure. We had nearly 50 ER techs and nurses, and I estimate that between 70 and 85 percent of them are no longer working in mental health. The work is hard, and the pay is less than for acute care so it's understandable.

Walmart pays more for overnight stocking than our overnight techs.

The pandemic closed these beds, but the challenges existed before COVID and so did some of the changes that need to happen.

First, we have to stop closing beds and get back the beds we lost and more.

We need more money. One reason I make so little is because we don't reimburse enough for these services. The amount we pay staff for these services, in many ways, reflects the value we put on them. We tolerate underpaying mental health staff because we don't value the services. This has to change.

These patients need more therapeutic services. Medication without therapy is not successful and we need to devote more time to their treatment.

Finally, we need to staff based on acuity and not census. Many of these patients can require two and sometimes three staff to manage them when they are in crisis. We need to staff accordingly.

The pandemic laid bare some of the chronic challenges facing healthcare. We saw it in the nursing homes and staff burnout in hospitals. Mental health was no different. With crisis there is opportunity and I hope we learn from this crisis and finally tackle the challenges faced by both mental health patients and staff.

Sandra Brower / New York, New York

This testimony is about the bad administration and medical care I experienced at a nursing home and public hospitals. I was stigmatized as a person with a mental health condition. My care at Park Nursing Home was rotten and actually worsened my health. Two of my close friends contacted the Attorney General's office because they were so worried about my treatment. Four people died while I was there. My care coordinator and I found out that Park Nursing Home stole from Social Security. An administrator at the nursing home cashed my social security at a JP Morgan Chase, but Chase refuses to help me get my money back. At Park, I was threatened by an administrator named Michael Melnicke, the nursing home falsified my medical records, I got an infection, and I was even almost murdered. Although I no longer live there, it is still impacting my wellbeing and behavior to this day. Park put me in Kings County Hospital, although I did not belong there because I no longer have suicidal thoughts. The care at Kings County Hospital was even worse than at the nursing home, and I also received terrible care at a medical respite center afterwards. Kings County responded to most of my problems by forcibly injecting me with medication. The doctors neglected me. I still have lasting trauma from that experience. In fact, just writing this testimony has severely increased my anxiety. Thinking of my experience at Park brings me to tears.

Judy Balaban / Bethel, New York

I have lived in Sullivan County for 36 years. The availability of mental health services has always been scarce. At the present moment is dangerously inadequate to meet the needs of our community. I have outlined my concerns below.

The way funding is distributed in NYS only takes the population numbers into account and not the needs of the residents of the counties. This leaves rural communities, such as Sullivan County, without adequate funding for care. This is at a time when our needs are extreme.

Medical transportation is not available to transport people in need to appropriate facilities.

We are not paying a livable wage to clinicians in Sullivan County, so clinicians with experience are leaving for adjacent counties where they can make more money.

We do not have a mobile mental health unit that is available 24 hours, 7days/week. The night shift, when issues are very high, is not covered by a reliable mobile mental health unit.

We need community health workers, who are compassionate, and trained to evaluate and refer residents to appropriate services. They need to do outreach in the community, since many residents in Sullivan County cannot get to services because of a lack of transportation.

I have had personal experience with my son who had a substance use disorder years ago. He could not get appropriate services in Sullivan County.

Please help, these are lives and not just numbers.

Norman Thomas / Queens, New York

Good day, my name is Mr. Norman Thomas, and I currently live in a Catholic Charities housing. I am now facing eviction for the past three years at the address listed above. I have not been appointed an attorney or assistance with my case. I have mental issues, and to date, no counselor from this organization has checked on my well-being or managed my medication compliance. I am on my own.

My application for rental assistance was provisionally approved, and this organization still sent out a court date on February 23, 2022, to have me evicted. I showed the judge my provisional approval, and the case was held over.

I do not understand how this organization is collecting money on my behalf, and I have not been receiving any services. I want to be appointed a lawyer to help me acquire the necessary help for my human rights. Please, I do not want to be homeless again. I need HELP. Thank you for your kind cooperation in this matter.

Patricia Quinn / Unionville, New York

Thank you for holding this hearing. The mental health crisis is very dire, and your hearing is so important. There has been much made of the Adverse Childhood Experiences (ACES) of 1998 & 2003 that show the impact of untreated ACES that bloat the health care budgets when chronic mental and physical conditions develop as a result in adulthood. I want to bring forward a little understood hitch that has affected New Yorkers and my career for 50 years as a Creative Arts Therapist. The political and economic practice of scarce resources for mental health since the late 1980s have marginalized a profession that children can really use to heal. We are trained to use the arts to help people, including children, to communicate more broadly and deeply. Yet we are prevented from billing Medicaid and Medicare and insurers are not

required to pay for our services despite being one of the 4 licensed mental health professions. The lying we have uncovered to legislators by lobbyists by other siloed professions is one reason our bills for parity of payment have not succeeded. The exclusion has gone on so long that programs that teach psychotherapy with expressive arts are floundering because of suppression at the Office of Professions, commissioners and others who set policy. I can only treat children privately because of this prejudice and politics. My master's degree was honored by OASAS, presumably because they require less specificity of providers, and my skills enabled me to treat the problems of my complicated adult patients very effectively. I wrote a book about it, Art Therapy in the Treatment of Addiction and Trauma (2021) because the quality of mental health treatment of people with addictions is appalling and needs attention. There is a direct line between childhood and addiction and the arts bring this out immediately and can treat these adversities expeditiously and safely. Thank you!

Andrea Smyth / Albany, New York

I am Andrea Smyth, the President & CEO of the NYS Coalition for Children's Behavioral Health, the leading advocacy voice in New York for improving access to mental health capacity for children and their families.

Overview of the Children's Mental Health Crisis and Need for Accountability

The children's mental system has been unable to sufficiently respond to rising demand for children's mental health, substance use and preventive services. In October 2021, the American Academy of Pediatrics and Hospital Association declared a NATIONAL STATE OF EMERGENCY in children's mental health, citing Centers on Disease Controls' youth suicide data and unmet need for services. Other specifics include:

» Nationally, according to a survey released by the National Council for Mental Wellbeing in October 2021, demand for mental health and substance use treatment has increased nearly 80% over the past three months, continuing a steady rise that began more than a year ago.

» In the same month, 76% of the Coalition's member agencies reported that they have paused intake for services because of workforce shortages.

» And nationally, over 140,000 children have lost a parent or caregiver to the COVID-19 virus, about 7,000 of them New York's children. The adverse childhood experience of losing a parent or primary caregiver sets every one of these children up for higher risk of unhealthy, unproductive lives based on well-established research. The only remedy is immediate access to care and treatment that responds to their experience and the presence of a caring, supportive adult upon whom they can rely.

The question before us today is can New York State government, community-based providers and hospitals respond to the need? What more needs to be done to ensure an adequate response?

In the interest of time, I will summarize my recommendations based on my testimony.

» Expedite promised payments. This year, the State Budget authorizes investments in children's mental health services. Those funds need to be released immediately to respond to a crisis. There is little risk of not receiving Federal Financial Participation eventually so the state should release the funding now

» The rate increases can only result in improved access if there are workers available to hire. Diversify the mental health workforce by offering scholarships for Masters in MH graduate degrees – taking out loans and hoping for loan forgiveness is not an incentive

» Remove inpatient psychiatric beds from being eligible for the hospital "swing bed" authority

» Reform the admission process for children's residential treatment facilities by allowing direct physician referrals

» Avoid precipitous closures, provide emergency funding and require publics hearing prior closure of inpatient, residential or community-based beds or services.

State Budget: Investments May Help

The April 1, 2022 State Budget agreement include numerous investments into mental health services. These investments come after more than a decade of both active and benign neglect of the system, and some will not come in time because capacity is already lost. This is especially true for the OMH Licensed Children's Residential Treatment Facilities, a sub class of hospital in New York State that was created to avoid the federal IMD exclusion and allow for federal financial participation. The majority of my spoken testimony will focus on the RTFs, but I am including a written summary of the Hochul Administration's investments in the children's, community based and hospital psychiatric service array. These investments are welcomed, necessary, but without significant additional investments in workforce development, scholarships to encourage new practitioners, and loan repayment so clinicians in training can afford to work for the non-profit salaries, the investments may still be insufficient to meet existing needs.

General Workforce investments:

» 5.4% Cost of Living Adjustment (+$93.7M) and Minimum Wage ($5.4M)

» Healthcare and Mental Hygiene Worker Retention Bonus ($38.7M)

» $9M Recruitment and Retention Loan Repayment for Art 28 inpatient, Youth ACT and Art 31 Clinics

Non-Medicaid investments into Children's Services:

» $10M to expand school based mental health services in schools, students, and school staff

» $27M new RFP to expand HealthySteps for integration of mental health services into primary care settings

» $7.5M to expand Home Based Crisis Intervention (HCBI) programs for children which provide short-term, intensive, » in-home crisis intervention services to a family in crisis

» $10M to fund the Trauma-Informed Network to identify the range of experiences that may be trauma-inducing for young children and their families

» $8M to fund implementation of evidence-based treatments that improve access for children and families

Medicaid Investments into Hospitals, Children's Programs

» $27.5M to increase rates for inpatient psychiatric care

» $7.5M to increase rates for children's Residential Treatment Facilities

» $74M from Managed Care Reinvestment to support a permanent 5% rate increase for outpatient Art 31 clinics

Proposed, Not Implemented Rate Increases for other Children's Services

» 5% permanent rate increase for children's Partial Hospitalization Program

» 5% permanent rate increase for Youth ACT program (13 locations statewide)

» 4.8% permanent rate increase for Children's Community Residences (about 275 beds statewide)

» Temporary (6 month) continuation of a 25% legislated rate enhancement in 2021 for the failed implementation of the Medicaid Redesign Team's new home and community based and child and family treatment and support services. DOH not committing to making those rates permanent; reviewing cost reports

» All additional temporary rate increases afforded through the federal American Rescue Plan Act or Build Back Better workforce investments have not yet been implemented or released to the field.

The Coalition and Children's Residential Treatment Facilities

With enactment of Chapter 947 of the Laws of 1981, both the Coalition and the Residential Treatment Facility (RTF) came to be in New York State. The RTF was authorized to serve youth whose needs could not be met in the community or any other less restrictive setting. The RTFs could serve youth with serious diagnoses, between ages 5 and 21, if they did not present a likelihood of serious harm to others. Licensed by the New York State Office of Mental Health (OMH) were identified as a safe, 24-hour, structured environment that was one step below a psychiatric hospital in the continuum of mental health services to meet the needs of children and their families. OMH has full control over RTF admissions via the Pre-Admission Certification Committee (PACC) review process. Physicians cannot make direct referrals to an RTF.

In 1994, cracks in the reimbursement methodology appeared as OMH added unfunded mandates on the operation of RTFs to comply with state-created and new federal regulations.

In 1999, the Legal Aid Society filed a class action lawsuit that challenged OMH's practice of maintaining extensive waiting lists of child awaiting Pre-Admission Certification Committee meetings – meetings that only OMH can convene. At the time of the litigation, OMH noted that approximately 400 child were awaiting decisions about their admission to RTFs. Since Alex A v Novello, OMH no longer keeps waiting lists for RTF determinations.

Sin, from a high of 569 temporary and permanently licensed RTF beds statewide to a precipitous drop of over 40% of the remaining capacity between 2020 and 2022 without the state undertaking a bed need methodology effort or even a stress test on the system.

Details on Declining Capacity

Beginning in 2012, OMH stated that investments in community-based services were preferrable to out-of-home care. The Coalition agreed and was appointed to the Medicaid Redesign Team's Subcommittee on Children's Behavioral Health to identify investments in new community-based services that might better meet the needs of families. Implementation of the Children's MRT Redesign began on January 1, 2019, but the downsizing of the children's RTFs continued steadily, despite NO equivalent investment in community services taking place during the intervening years. Between 2012 and the present, the system shrunk while a 5 year old child who may have needed RTF services became a 15 year old without care; or a 13 year old became a 23 year old.

10 Year Bed capacity reductions = approximately 270 or 50% of capacity, without the state undertaking a bed need methodology exercise, without a single public hearing, without implementing a rate methodology reform, without any significant admission policy change or testing a direct referral option, without even performing a stress test on the system. The decline happened as a withering of a system based on an unmet promise of alternative care being developed for children and families:

YEAR	BEDS
2012	540
2013	534
2014	526
2015	526
2016	517
2017	512
2018	512
2019	427
2020	391
2021	274
2022	270

In 2013*, after years of advocating for a rate methodology modernization, reform of admissions procedures, reform to the hospital-like regulations without success, and a bed need methodology that could guide a "right- sizing" of the system in the face of Medicaid Managed Care reforms, the Coalition contracted with Manatt Health Solutions to perform an independent review of the RTF system.

Manatt found the RTF system on a collision course with state policy in their 2013 report entitled, "Redesigning Residential Treatment Facilities". Excerpts give the full picture of the problems in 2013 that continue and certainly contribute to the lack of safe out of home alternatives to the hospital emergency departments:

» RTFs remain subject to the same statutory and regulatory requirements that were put in place over thirty years ago and confront regulatory mandates that no longer align RTFs with their evolving roles in the children's mental health system, despite numerous proposals for regulatory relief;

» RTFs have not received any increases in funding since 2008—no trend factors, no cost of living adjustments, no rate enhancements—even as expectations continue to escalate regarding the roles they should play for children and families, both pre-admission through the actual episode of care and thereafter, after the child has been discharged and is re-entering family and community life;

» Anticipated reductions in the capacity of the five current State-operated children's psychiatric hospitals will inevitably result in increasing the number of children that may require RTF care, as well as increasing the complexity and severity of the emotional disturbances required to be addressed by RTF, which will require new investments in the RTF's clinical capacity and staffing resources to meet these new demands; and

» As the State embraces a care coordination/managed care approach to caring for children with severe emotional disturbances, RTFs remain largely unprepared for the demands of a managed care environment…

As you are well aware, the reduced capacity of the 5 State-operated children's psychiatric hospitals did occur and the RTF Rate Methodology is slated for a July 1, 2022 update. Almost a decade after, the Manatt report was released.

In that interim period, 7 of the 18 RTFs identified in the Manatt Report have closed and while the publicly facing OMH State operated hospital capacity for children and adolescents is difficult to reconcile with actual capacity, we know that both Rockland Children's and Hutchings Psychiatric have closed and the bed capacity statewide has fallen from over 500 to about 275 state operated beds.

To read the Manatt report in full, go to https://cbhny.org/publications

New Promises

I can report that OMH has submitted a request to the federal Centers for Medicare and Medicaid Services to allow for a 25% rate increase for the RTF clinical & direct services line in the Consolidated Fiscal Report, so that RTFs can increase salaries and hire additional clinicians. This is a recommendation the Coalition made in 2013. It may be effective on July 1, 2022, but payments will not be made until administrative approval is final – possibly another 6 months.

In conjunction with the promised rate increases in the intensive community-based services, like Youth Act, Partial Hospitalization and Home Based Crisis Intervention, it is possible that more children will access care.

There are 2 incredibly high barriers to that being the case:

1. There is a grave shortage of clinicians and with even 25% increases to the cost centers it is possible that no one will apply for the jobs; and

2. Every service is available in a sparse geographic pattern around the state – with gaps that are glaring, such as an RTF in the Bronx, but the next closest in Poughkeepsie, and the next closest to that in Albany, and the next closest to that Utica…

Let me be candid, based on services still operating in a geographic area, the luckiest child in need of a full continuum of mental health services lives in Erie County with 2 RTFS, 7 outpatient clinics, 13 providers of HCBS or CFTSS, a few community residences, and a YouthAct team slated to open soon, as well as a still functioning state-operated psychiatric center. However, I think we can all agree that no child in Buffalo in 2022 can be counted as fortunate at the moment and that all have been exposed to adverse childhood experiences, in the form of exposure to community violence. The demand for treatment is far outstripping capacity, even in a community with that, on paper, has sufficient provider capacity to meet need.

Recommendations:

1. Revise the public health law to require interim supports from the state to keep services operating when a provider files an application to close beds or services until a public hearing about downsizing can occur and an alternative provider in the area signs a contract to serve the area;

2. Mandate a change in the calculation of "network adequacy" if waiting periods to access care are longer than 3 weeks

3. Mandate that health plans that fail network adequacy tests must pay the government rate OR HIGHER to providers to keep them in the network until alternative providers are available.

4. Remove the "swing bed" authority of hospitals as they pertain to inpatient behavioral health services

5. Fund the MA in MH scholarship program to fill the pipeline with candidates for Licensed Mental Health Counselor, Licensed Family Therapist, Licensed Creative Arts Therapists and Licensed Clinical Social Workers so we can diversify the mental health workplace, offer clinicians who look like the children and families we serve, speak languages other than English and provide culturally appropriate care.

6. Pay out the promised rate increases now rather than when CMS gets around to approving them – the lives of children are at stake and the state can use existing resources to front-load the promised payments at minimal financial risk to the state.

Lucille and Roy Ettere / Somers, New York

Hello, my name is Lucille Ettere from Somers in Westchester County. I am a board member of NAMI New York State and NAMI Putnam County. My husband, Roy Ettere, who is with me today is also a board member of NAMI Putnam County and answers their warmline. We both volunteer with the Putnam County Suicide Task Force in Carmel NY. We would 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, body dysmorphia. She was 37 years old and was a very vivacious woman who worked diligently in the medical field for over ten 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 to visit her doctors and therapists. She was briefly hospitalized five different times after five suicide attempts from June 2017 through August 2017.

We were helpless and tried tirelessly to get her the help she so desperately needed. The five hospitals failed to provide Nicole with 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. Many times, discharging simply an appointment to visit therapist or psychiatrist. Although medical histories were taken at each hospitalization, no collaboration was done with 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 need.

When entering the hospital emergency room after a suicide attempt and if that person has made prior suicide attempts, that patient 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 received follow up support after discharge to ensure she was adhering to her 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 in-depth evaluation/diagnosis, collaboration between doctors and hospitals both within the hospital and between previous hospitals where the patient was seen or treated. Create a red-flag law which will alert hospitals/doctors/social workers/psychologists that the patient experienced a previous suicide attempt and needs intensive treatment. Make sure there are enough beds available in all hospitals to care for these patients.

NAMI New York State had presented a law, Nicole's Law, to the legislative session prior to COVID and 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 to share our story with you. We wish to collaborate with you, not to fill the void in my 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 heal those who have experienced a loss in their family by beginning to create memorial gardens where people can visit, reflect and begin to heal.

Please protect the most vulnerable of the mentally ill.

Julie LeClair / Bronxville, New York

I have a doctorate in clinical psychology and a private practice, and I am the mother of a daughter with bipolar disorder. I also am on the boards of NAMI-NYS and NAMI Westchester. My daughter Alexandra LeClair, nicknamed Alix, was diagnosed with bipolar disorder her freshman year at Dartmouth College and was hospitalized with a manic episode in 2009. She passed away in 2016 at age twenty-five. Alix was a talented writer. She published a paper advocating for those with a mental illness and participated in Active Minds to fight stigma on campus. Her psychiatric hospitalization enabled her to get back on track and return to college. Unfortunately, she herself was stigmatized at Dartmouth after she emailed her entire freshman class from the psychiatric ward, and she later transferred to New York University. Alix excelled at New York University for two and a half years and even studied abroad in Germany. But then she had a manic episode after her grandfather died in 2012. She was hospitalized but discharged too early from the hospital. Then she was arrested at a bar while still in a manic state. The front door slammed when she was being evicted, a glass panel in the door broke, and, because of the damage to the glass, Alix was charged as a felon and placed with murderers on the prison unit of a hospital. Over sixty percent of those in jails and prisons in New York state have a mental health issue and could have benefited from treatment, and in some cases an inpatient hospital bed, rather than prison. Many of those with a mental illness also end up homeless. Indeed, when my daughter would become manic, she would want to run away and live on the streets. Eventually my daughter's charges were dropped, and she received much needed inpatient treatment at a psychiatric hospital. Alix went on to need other hospitalizations for mania and occasionally for depression. It would be touch and go once she was admitted to an emergency room as to whether an inpatient psychiatric hospital bed could be found. In 2015 she was sent from a New York ER all the way to Connecticut for a hospital bed. If no bed had been located, she would have been released in an unsafe state of mind. Alix's inpatient psychiatric hospitalizations were vital for her ability to recover from her manic episodes in a safe environment where she received therapy and medication. After she

died, New York University posthumously awarded her a college degree. At her funeral, numerous fellow inpatients from her psychiatric hospitalizations came to Alix's funeral. One woman told me how much Alix had inspired her on the inpatient unit. She said Alix was a tortured soul sent down from heaven to uplift everyone. Other women who'd overlapped with Alix from various psychiatric inpatient stays approached me and said Alix had lifted their spirits as well. Alix made a difference to others even while she was in the throes of mania. One fellow inpatient couldn't come to the funeral. She later flew in from California to read a seven-page letter at Alix's gravesite. She told Alix that she was enrolled in medical school classes and wouldn't be where she was if it wasn't for Alix; that Alix had found her in some sort of darkness and saved her, and she would name her first child after Alix. Alix's hospitalizations helped her and provided a sense of community and care for her and for all of those other people with a mental illness who also received an inpatient hospital bed and later attended her funeral. It is critical to have enough inpatient psychiatric beds to provide appropriate treatment and to avoid prison, homelessness or death. Thank you for allowing me to testify and speak today and for giving my daughter a voice even beyond the grave.

Betsey Lazarus Rouse / Bayside, New York

I am NYS licensed Creative Art Therapist practicing in Bayside, NY.

NYS Bill A1171A was passed by the legislature May 24 and must be signed by Gov Hochul within 30 days in order to become law.

This bill will provide blanket health insurance for outpatient treatment by New York State licensed Creative Arts Therapists, Mental Health Counsellors, Marriage and Family Therapists and Psychoanalysts. This is a time of critical importance for making quality mental health services affordable. Our children are experiencing mental health crises and the creative arts therapies especially offer a unique and effective approach to help. Trauma in the covid era abounds and the need is immediate and overwhelming the system. Ensuring the New York State of health for all citizens demands a wider range of practitioners as many are burdened by long waitlists.

Bill A1171A has not yet been signed by Gov Hochul and time is of the essence.

I, and many of my cohorts, friends, family and clients have been urging the governor to sign this bill and expand availability of affordable quality mental healthcare to New Yorkers. There are literally hours left for Governor Hochul to make good her commitment to mental health in New York State, which underlies many if not most societal problems.

Mark Graham / New York, New York

I am the Executive Director of a transitional supportive housing program in New York City called The Redemption Center. I have two Masters' Degrees, including a Master's in Divinity. I am also a certified Peer Advocate with the Bridge Back to Life Program. In addition, I am a proud member of the Treatment Not Jail Coalition. If passed, The Treatment Not Jail Act (S.2881B-Ramos/A.8524A-Forrest) will expand existing law to permit treatment courts to accept people with mental health diagnoses, intellectual disabilities and other disorders that have impaired their functioning in society and have led to criminal legal system involvement. Thank you to the Attorney General for hosting this hearing on this critical issue.

Every day I bear witness to the ways that New York's mental health system is fundamentally broken. My experience navigating the failings of the system are not just professional, but also personal. Through my testimony, and the stories I share about the people I work with, I hope that the Attorney General will decide to put her full support behind increased funding and capacity for high-quality, community-based treatment options for all New Yorkers, including those with criminal legal system involvement. I also call on the AG to support the Treatment Not Jail Act, which is currently pending in the State Senate and Assembly.

My Story

I am extremely fortunate to be here today because my life should have gone in a very negative direction. I spent three years in juvenile prison, starting at 13 years old, followed by22 horrific continuous years in an adult prison starting atage17. I received no help whatsoever for my addiction and mental health struggles before I entered into New York's carceral system. Prison was supposed to act as a deterrent to keep me from getting in trouble in the future. But while there, I was exposed to gangs, makeshift weapons, violence, and drug use. I learned all about guns, how to commit robberies, how to sell drugs, how to steal cars and a host of other criminal activities that I never knew existed. I walked into Juvenile Detention a novice and walked out knowing what it was to be a criminal, which led to my two plus decades in New York's adult prison.

But somehow, the angels were with me because my once-vulnerable life has had a far better outcome than the great majority of my peers. Good outcomes are difficult-to-impossible for people leaving incarceration, as evidenced by the overwhelming prevalence of homelessness, unemployment, poverty and, yes, recidivism, among formerly incarcerated people.

The Intersection of the Criminal Legal System and the Mental Health System

Indeed, the United States releases over 7 million people from jail and more than 600,000 people from prison each year. Leaving prison should mean having a fresh start, but for most returning citizens it presents even greater challenges. Within years of their release, two out of three people are rearrested and more than 50% are incarcerated again. The rate of recidivism in the United States is 70% within five years of release. In New York, our rates of recidivism reflect national trends and are unacceptably disturbing. An estimated 45% of all parolees in New York City experience a re-arrest within two years. For people with mental illness, incarceration brings about an even worse outcome. In New York City, these individuals return to jail nearly twice as fast as those charged with similar crimes but who do not have mental illness. Those diagnosed with psychiatric disorders, such as alcohol and drug use disorders, personality disorders, attention-deficit hyperactivity disorder, or schizophrenia disorders, face a higher risk of reoffending and committing violent offenses upon release than those without diagnoses.

How Our Current System Fails the Most Vulnerable New Yorkers

In my current work as a Peer Specialist with Bridge Back to Life, I counsel formerly incarcerated people in two different psychiatric hospitals in our city. In one of the hospitals I am on the Mobile Crisis Team. Monday through Sunday each week, I witness the grotesque and dehumanizing revolving door that exists for people with untreated mental health and substance dependence challenges who were released from prison after serving their sentences. The majority of people with behavioral challenges who are released from New York's jails and prisons become homeless, mentally unstable, and drug and alcohol addicted from the moment they hit the streets. These are my clients, and sadly, many of them are "repeat clients." These people face stigma, discrimination, isolation, and instability. If they are not engaging in self-harm, attempting to take their own lives or overdosing on drugs, they are getting re-arrested for violent and non-violent offenses placing themselves and our communities at risk. This is what jail and prison does to people.

I want to share a recent story of a man I worked with just last week at a New York City psychiatric hospital. He faced all of the challenges that you could imagine one could face: severe mental health issues, chronic health conditions, recently returned from prison, and kicked out of his housing because of an issue with another resident and now facing a new criminal charge and violation of his parole. We were trying to help this man find a safe option for treatment upon his release from the psychiatric hospital and no matter what avenue we pursued, we could not find a bed for him. Every program we spoke with said his needs were too complex and they couldn't treat him. This includes hospital-based treatment settings. Even the hospitals said they could not/would not treat him. If we cannot find him a bed, he will return to Rikers Island and could face prison time.

Jail and prison will not cure his mental health issues. But instead of offering the sickest among us real meaningful treatment options in the community, where we know people are more successful, we force our jails and prisons to handle them. Incarceration then makes them even sicker, and the broken cycle perpetuates itself. Our current approach is not keeping our communities safe.

Investing in Mental Health is Investing in Public Safety

Too often, people buy into the false narrative that incarcerating members of our community who are involved in the criminal legal system make others in our community safer. These narratives prey on our community's fears by repeating this fallacy over and over. However, a robust body of research analyzing the impact of incarceration -in New York and nationwide -indicates that being in jail and prison actually makes someone more likely to re-offend. The reasons for this are not hard to identify. Incarceration is incredibly traumatizing and destabilizing. The people we send to jails and prisons are too often left to languish during their time inside with inadequate mental health treatment and medical care. Moreover, once their period of incarceration ends, these individuals are released without stable housing, medical care, mental health services or rehabilitation systems in place. These individuals are then expected to gain employment, housing and benefits while navigating the adverse collateral consequences that accompany a criminal conviction. This increases risks for substance use, exacerbated and untreated mental health conditions, and inevitably, further involvement with the criminal legal system -all at the expense of public safety. Meanwhile, the data show that people who successfully complete mental health or drug diversion courts, should they be lucky enough to be eligible for them or accepted into one, have a significantly lower rate of recidivism. Moreover, diversion is proven to be significantly more cost-efficient than incarceration. While New York City spends $556,539 per year to incarcerate just one person in its jail system, the New York State Office of Court Administration reports that every $1 invested in treatment courts yields $2.21 in savings. In short, investing in mental health courts, community treatment and housing is a far more cost-effective and stability-promoting use of state resources than incarceration. Just imagine if a portion of money poured into New York City's noxious jails could instead be diverted into our communities to fix our housing shortage, increase mental health services, increase the number of hospital beds, and significantly, increase pre-trial judicial diversion opportunities, which are proven to reduce recidivism.

Recommendations

We must start by shifting hundreds of millions of dollars to fund unmet supportive housing needs for the thousands of people who are currently cycling in and out of jails across the state. We must then continue funding for community-based mental health and substance use treatment, an expansion of our state's treatment courts as envisioned in the Treatment Not Jail Act (S.2881B-Ramos/A.8524A-Forrest), and other commitments made in the Points of Agreement on Closing Rikers.

We have a responsibility to rely on facts and not fiction when life-impacting decisions are being made by our elected officials regarding whether to pour more money into our city's jails as opposed to our communities and to understand how impactful such a move will be on protecting public safety. New York City has spent almost 3 times (290%) more per incarcerated person than the second most expensive jail system in the country, yet people in DOC custody are subjected to some of the worst jail conditions in the nation.

Funding that is being spent on systems that are not working, that hurt people, and cause more harm than good is unworkable. Nor does it protect lives-the lives of those who become entrenched in the criminal legal system because of a diagnosable condition under the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or the victims of crime who seek public safety. When I speak to state legislators about the Treatment Not Jail Act,I am speaking from first-hand experience and knowledge. We are locking people up with no treatment and then releasing them thinking and believing that we have made the public safer. What we see going on in our subway system right now, and throughout the communities in New York State, is the result of misleading narratives about incarceration and recidivism. If we want a different result, a safer result, a more effective result, then we must do something different. Funneling more and more money into our corrupt and inhumane jail system is the equivalent of saying that we want things to continue the way they are. Instead, I urge the state to dramatically increase investments into solutions, like Treatment Not Jail, that pull people out of this horrific cycle of suffering and recidivism that incarceration causes.

Meaghan Obergh / Bay Shore, New York

I currently work for a short-term crisis intervention program for children with mental illnesses at Family Service League and am the sole part-time worker, accompanied by another worker who dedicates a few hours a week to the program. Our program has consistently been receiving a high number of referrals in the past year, with many children presenting with school refusal and anxiety, after the COVID pandemic. Our program currently does not have enough funding to hire more workers, which are desperately needed as a result of the influx of referrals. I currently carry a caseload of 14 children and work 26 hours per week. I spend an hour with each client, to ensure they receive adequate services during our sessions. I individually plan each session at the beginning of the week and customize activities to the need of each child I work with. I strive to ensure each child gets the most out of the 3 months I work with them, However, if the program was longer (6-months), or we could hire another worker, I could really provide the appropriate time to each family. 14 families for someone working 26 hours per week is simply not feasible--if the worker is expected to give the appropriate, individualized attention to each family. Further, if there were more workers for preventative programs like mine, there wouldn't be children on a waitlist waiting for services they desperately need. The COVID-19 pandemic has created a mental health crisis among school-aged children and services need to be adjusted as a result.

Irving Campbell / Queens Ville, New York

My name is Irving Campbell. I have been a registered nurse for over 20 years and recently fulfilled my dream of becoming a Psychiatric Mental Health Nurse Practitioner. I have been practicing in the community, serving those diagnosed with Serious Mental Illness (SMI). I am also a proud New York State Nurses Association (NYSNA) member and a mental health advocate. I would like to thank you and your office for this opportunity and forum to speak on such an important topic. I am unfortunately too well aware of the dangers that come when our communities do not have adequate access to mental health care, namely inpatient psychiatric beds. Before the pandemic, I worked for eight years in the inpatient psychiatric unit at New York-Presbyterian Brooklyn Methodist Hospital (NYPBMH)—before seeing many institutions, including NYPBMH, repurpose their psychiatric units to take in Covid-19 patients. I understood the need at the time, but years later, many of these beds have not been reinstated despite vaccines, other medical advancements, and decreased Covid-19 hospitalization rates. Most clearly, these beds remain inaccessible because they are primarily used by those whom Medicaid insures, and the reimbursement rates for these individuals are extremely low. The loss of inpatient beds includes the 52 beds at New York-Presbyterian Brooklyn Methodist Hospital, which were accessible to the people of Brooklyn, NYP Allen, and Northwell Syosset, to name a few. Unfortunately, this created a mental health void for the community and surrounding communities, including many communities of color and those with lower socioeconomic status.

The pandemic helped expose the need for these inpatient beds. The National Institute of Mental Health states that 18.5% of adults experience mental illness annually, 1 in 5 youth aged 13-18 (21.4%) experiences a severe mental health condition at some point during their life; for children aged 8-15, that estimate is 13%, 20% of state prisoners and 21% of local jail prisoners have a recent history of a mental health condition, 70% of youth in the juvenile justice systems have at least one mental health condition. A staggering 60% of adults and almost 50% of youth ages 8-15 with a mental illness received no mental health services in the previous year. At the same time, African-Americans and Hispanic-Americans used mental health services at about half the rate of Caucasian-Americans in the past year. You may wonder how this equates to real dollars; well, mental illness costs America $193.2 billion in lost earnings per year. Mood disorders, including major depression, and bipolar disorder, are the third most common cause of hospitalization in the U.S. for youth and adults aged 18–44. Suicide is the 10th leading cause of death in the U.S., the third leading cause of death for people aged 10–24, and the second leading cause of death for people aged 15–24. More than 90% of children who die by suicide have a mental health condition. Two million people with mental illness are booked into jails each year. While incarcerated, at least 83% of jail inmates with a mental illness do not have access to needed treatment, and as a result, their conditions worsen. Many are released with no continued access to mental health care.

All statistics show the need for inpatient psychiatric beds as we have seen an increase in anxiety and depressive disorders, substance use disorders, and suicidality. In addition, children are effected where the suicide rates for those under 18 increased tremendously during the pandemic. Children not only experienced grief and loss, but isolation due to our city being on lockdown and not having enough psychiatric beds. As a medical professional, I witnessed the direct need at my facility, patients with active suicidality waiting for 96 hours in an overcrowded emergency room for an inpatient psychiatric bed only to be transferred to as far away as Westchester Medical Center away from their community and support systems. Unfortunately, this was not a select few but rather the norm. Throughout my institution, we cared for and are still caring for patients who would generally be on the inpatient psychiatric unit, now on medical-surgical units while not receiving care from trained psychiatric mental health nurses.

The need is glaring; we continue to see New Yorkers experience mental health symptoms daily with very few places to go. The city has promoted NYC WELL and Governor Hochul spoke of millions of dollars going directly towards psychiatric beds; however, this has yet to be seen. New York-Presbyterian Brooklyn Methodist states that they will resume inpatient psychiatric services potentially in September of this year. They have invested millions of dollars into remodeling a unit only to bypass the certificate of need process. They intend to cut two beds on one unit while remaining non-committal when or even if the other unit will reopen. The institution has however remained committed to using that unit as an ICU unit for Covid-19 patients. One would think that we have learned our lesson after witnessing the increase in violence, suicide rates among children, and an indisputable need for inpatient psychiatric beds. Yet, we continue to penalize those with mental illness and lack of resources. Unfortunately, this often leads to incarceration and not receiving the necessary care. Worse, we have innocent victims such as Michelle Go, who was pushed in front of a train by a man who is believed to have a psychiatric history.

You may ask what can be done. My simple answer is to immediately reopen all inpatient psychiatric units that were closed in relation to the pandemic. We can also push to enact bills that will hold institutions such as NYP accountable for purposely keeping these beds away from those who need them the most. It is the least we can do for those members of our community who require access to mental health beds. History has shown that we lose countless beds every year, never to come back, but now is the time we must respond to the mental health crisis and put an end to the loss of beds, for if we fail to do this, the future of our children and those we love will be at risk. Thank you once again for this opportunity to contribute to this discussion. I look forward to other forums such as this in the future.

Rina Riba / Roxbury, New York

I am a retired medical social worker and disability advocate and have been active for many years with NAMI Delaware and Otsego Counties as well as NAMI New York State (www.naminys.org), the state chapter of the National Alliance on Mental Illness (www.nami.org). I have also been a member of a number of committees and coalitions in Delaware County: the county's Community Service Board, Mental Health Subcommittee, Suicide Prevention Network, the Margaretville Hospital Wellness Committee, and the Catskills Addiction Coalition (www.catskillsaddictioncoalition.org).

I deeply appreciate the opportunity to present my concerns to your public hearing on the mental health crisis in our state.

Although I will not be able to attend the hearing in person, in Manhattan, I hope you and your staff will pay close attention to what I have to report in this letter, if the meeting will not include participation in virtual Zoom format.

To begin with, the enormity of the problem of the COVID pandemic must be acknowledged and addressed.

The increased burden on workers in all kinds of health care, and at all levels of expertise or hands on care, has led to such a serious loss in numbers of providers, yielding yet another layer of challenge to anyone needing care or treatment. And to extreme pressure on those workers who remain after others have left the field, which may lead to more worker exits. We need to create supports for existing workers and incentives for recruiting newcomers to the field.

Besides the issue of the complex symptoms of the physical illness needing treatment and calling for adherence to all kinds of preventive measures, the serious emotional and cognitive outcomes that often result from this illness call for intensive planning, programs and ample funding for dealing with "long COVID" that will affect many people.

For people already living with mental illness, such an impact, comparable perhaps to PTSD (Post Traumatic Stress Disorder), can add a significant additional burden to the struggles they are already having to deal with.

As for any health care, both physical or mental, providing adequate funding up front to manage these issues should be seen as an investment in care that will prevent much more costly situations, like emergency room visits and hospitalization later on.

Following is a list of the challenges to all levels of care, for both physical and mental health, that many of us have been concerned about and seek to find ways to get addressed in our very rural region:

» There are no inpatient psychiatric beds anywhere in Delaware County, which in area is larger than the state of Rhode Island. Bed numbers in the surrounding region have declined drastically over a number of years and are very long distances away for our residents. Reports of frustration with limitations of available CPEP (psychiatric emergency units, again, outside of our county) services have come from families and practitioners, as patients are reported to have been sent back home quickly without being admitted to inpatient care due to the lack of beds anywhere.

» Some years ago, when A.O. Fox Hospital in Oneonta merged with Bassett Health Care in Cooperstown, Fox's inpatient psychiatry units were closed, and the overall number of adult psychiatric beds was reduced. Those for adolescents, the only ones for a large geographic area, were closed altogether. A few years later, in 2014, there was a move by Bassett to close adult inpatient psychiatry completely. But with strong pushback from the community, and review by the state Office of Mental Health, they were required to remain open, but did so with a reduction from 20 to 10 beds.

» In 2020, the Health Alliance of the Hudson Valley in Kingston, a division of Westchester Medical Center (WMC), closed inpatient behavioral health beds and sent these services to the Mid-Hudson Hospital in Poughkeepsie, due to reserving beds for COVID needs, early in the pandemic. After much appeal from the community, as well as NAMI and the New York State Nurses Association (NYSNA), some beds are planned to reopen, but the number is 20, down from 60, and I don't' know if this number includes some for treatment of substance use disorders, in addition to psychiatry. I don't think there are any planned for adolescents or children. In announcing the re-opening, a WMC official noted

the closing of psychiatric beds throughout the USA. My impression is that this has been due, for some time, to the continued cuts in insurance coverage for mental health treatment. Despite legislation requiring parity in coverage with that for physical health care, legislation which I believe needs increased enforcement.

» Greater Binghamton Health Center, the state Office of Mental Health hospital that covers our region, has had a steady and drastic decline in adult inpatient beds over several years. I do not have information on the status of their children's services.

» Our Mobil Crisis Assessment Team (MCAT), operated by the Neighborhood Center in Utica (www.neighborhoodctr.org) frequently is short of workers. A few months ago, I heard that three out of the four counties covered by this program did not have workers to cover their territories. We in Delaware County have had some excellent workers, but retention is extremely difficult. This is understandable, considering the high level of responsibility and extent of catchment area to cover in this geographically very large county, with mountainous terrain, rural roads, and winter weather conditions to drive in.

» Although the planned 988 crisis line program sounds promising, I suspect that it will take a while to establish sufficient staffing for it. I'm also concerned about whether there will be adequate resources in some communities to refer callers to.

» Our county mental health clinic also has difficulty in attracting and maintaining an adequate number of clinicians, and this has been the case for many years.

» We need to have an expansion of other community services, such as respite homes in the Rose House model, created by People USA (www.people-usa.org) some years ago, and crisis stabilization centers, like the ones in Dutchess County and on Long Island.

» Note that Delaware County has no public transportation system. This is a very difficult challenge for anyone who doesn't drive or have a support system to help them get to appointments for treatment, community services, employment, court dates, etc.

» Internet and cell phone service are limited in some areas, whether due to geographic challenges, limitations of community resources, personal economic struggles, etc.

» We need to have a system of diversion for mental health services in place of incarceration in county jails, for those individuals with serious mental illness who come in contact with law enforcement. For those who do enter the jail system, we need to have appropriate assessment and treatment during their stay there. And we need appropriate and ongoing training for law enforcement and 911 dispatcher personnel as well.

» We need careful coordination of treatment for co-occurring disorders, for those who need it, that addresses both psychiatric and substance use disorder treatment.

» We need to have good community education in place to address issues of stigma for people with mental illness and encouragement for seeking treatment and support for anyone experiencing any symptoms.

» Delaware County has long had one of the highest rates by county of suicide in NY state, partially due to the availability of guns among our rural residents. In addition, the issues of isolation, economic insecurity, and our aging population are risk factors for depression and suicidality.

» The limited availability of private mental health practitioners, many of whom are not accepting new patients, alongside the frequent shortage of clinicians at our county mental health clinic. Both of these create difficulty for people needing mental health care.

» For many years we have had only one psychiatrist in all of Delaware County, who is at the county clinic. More recently some psychiatric nurse practitioners have opened practices in our communities. We could use more of these.

» The gun safety issue: What needs to be done to maximize the effectiveness of background checks and red flag laws?

It seems to me that, up to now, a documented history of mental illness is looked for, but how do we identify potential danger for people who don't have such a record. Bear in mind that it has been demonstrated statistically that people with mental illness are many times more likely to be victims of violence than perpetrators.

How do we identify someone who may not have anything that is deemed to be a "mental illness", but who may become agitated when under the influence of alcohol or other drugs, or act out with uncontrolled anger at a life event (e.g., breakup of a relationship, loss of a job or of a home, disagreement with another person, etc.)? How do we identify other possible causation(s) for violent behavior?

We need to have input from behavioral health experts, and with peers and family members in crafting such legislation.

Patrick Lyons/Wayne Spence / Latham, New York

My name is Wayne Spence and I am the president of the 50,000-member strong New York State Public Employees Federation (PEF). I want to thank you for the opportunity to speak to you about access to services and care for those suffering from mental health conditions. Our union is made up of professional, scientific and technical experts who provide critical services to the residents and taxpayers of New York State. Serving as the state's frontline essential workers during the COVID-19 pandemic, my members have risked their lives and those of their families to maintain the continuity and quality of services to New York's most vulnerable citizens. PEF members are the frontline workers who care for the state's most acute patients with mental illness. PEF members take a great deal of pride in their work and the care that they provide to clients because they are professionals and they care about the welfare of their fellow New Yorkers.

I. Challenges Facing Efficient And Effective Service Delivery For At-Risk New Yorkers

The mental health staffing and service delivery challenges facing the state are not new, but these challenges have certainly been exacerbated by the COVID-19 pandemic. Due to the efforts of the previous administration's self-described "transformation agenda," the state of New York has actively worked to divest itself from providing comprehensive services for the mentally ill, as most recently exemplified by the consolidation of the Hutchings Children's Psychiatric Unit at Hutchings Psychiatric Center into SUNY Upstate, the investment of $21million of taxpayer dollars for the establishment of 15 new, privately-operated Youth Assertive Community Treatment Teams and another $14 million into14 new, privately-operated Assertive Community Treatment (ACT) teams.

While PEF believes there is a role for for-profit and not-for-profit providers in solidifying the state's mental health and social service safety net, these providers are not stable enough to serve as the primary vehicle of care for all of our mentally ill. We believe the previous administration's overreliance on the private provider network diverted too many resources away from the state's service delivery system and left too many New Yorkers and their families alone to deal with their illnesses. PEF is thankful to Governor Hochul for increasing the OMH budget by almost 7%and committing to fill staffing vacancies caused by the "hiring freeze," but this modest investment will not undue a decade of damage.

According to the 2022 Executive Budget Briefing Book: "Since FY 2015, the expansion in community-based services has resulted in nearly 106,000 previously unserved individuals receiving services, including over 2,100 individuals served in reinvestment-funded supported housing beds. The success of these community investments has resulted in the reduction of nearly 800 unnecessary, vacant inpatient beds over the same period."

The fallacy with this statement is that private providers have no duty or obligation to render care and are often unable or unwilling to care for clients with needs that are either beyond their capacity or who require longer-term, resource intensive treatments that challenge their operating margins. It is for these reasons that many of the most profoundly ill clients find their way to state-operated facilities and programs to receive care or simply remain in their communities without access to care. According to OMH, "For those people whose illness is complex or results in substantial disability—or for those who lack insurance coverage or for whom mental health benefits are inadequate—more is often required. This is where the OMH 'safety net' is essential."

The other problem with the continued over-reliance on private providers is that they are more prone to program consolidation and closure based on any number of factors, including staffing availability, utilization and financing. When these programs and facilities close or reduce services, clients and their families are forced to scramble to find other treatment options. Those options often involve substantial travel to distant locations and/or treatment at state-operated facilities and programs.

Because of the failure of the "transformation agenda" initiated by former Governor Cuomo, as demonstrated by tangible and intangible factors such as the rise in suicides, crime and homelessness in every community across this state, PEF continues to advocate that New York "Fund Our Future" by expanding public services for the mentally ill and other at-risk individuals to ensure appropriate and continuous access to quality care for all New Yorkers with the goal of keeping affected New Yorkers in close proximity to their families and other support systems.

1. Bed Closures at OMH Reduce Access to Mental Health Services

According to the 2020 Census, New York state grew by more than 1.6 million people in the two decades since 2000 and the state's population is now approaching 20 million residents. The Treatment Advocacy Center, a national thinktank and advocacy group for eliminating barriers to effective mental health treatment, recommends states maintain 50 in-patient beds for every 100,000 residents. According to this formula, New York state should maintain at least 10,000 in-patient residential beds. At the state level, we currently have approximately 3 273funded beds 2,203 for adults and 314 for youth.

	2015-16	9/2021	Change	% Change
Adult	4,055	2,203	-1,852	-45.7%
Children/Youth	528	314	-214	-40.5%
Forensic	1,469	756	-713	-48.5%
Total:	6,052	3,273	-2,770	-45.9%
NYS Population	18,976,457	19,835,913	859	+5%
NYC Population	8,008,278	8,804,190	795,912	+10%

According to OMH, private provider networks maintain 5,064 adult beds and 736 youth beds for a total of 5,800 privately operated beds across the state. This generates a total of 8,317 inpatient psychiatric beds statewide. That is far below the needed amount in the best of times.

PEF is very thankful for the legislative efforts this past session to restore 100 of the more than 290in-patient, youth and forensic psychiatric beds closed across the system as part of the 2021 state budget. While PEF appreciates these restorations, New York State has still closed more than 2,600 publicly-operated beds since 2015. These bed reductions continue to dramatically impact New York's most vulnerable residents and families by forcing them to travel greater distances and pay higher costs to receive critical mental health services.

For those with the most profound mental health issues, it is a matter of income. If you are a family of means, you may be able to find suitable treatment in your region or, if that isn't available, you can afford the travel costs, food and lodging to seek treatment elsewhere. However, if you are uninsured, underinsured, undocumented, indigent or happen to have a highly resource-intensive condition, you may not be able to get services from a private provider no matter how far you travel.

2. Continued Staffing Reductions Across State Agencies Equal Higher Costs and Cuts in Services

A simple comparison of the 2010 and 2020 NYS Civil Service Workforce Management Reports reveals a disturbing trend in the reduction of staff who deliver state-supported mental health services to vulnerable New Yorkers.

PEF members provide treatment for the mentally ill and the developmentally disabled. It is an intensive endeavor that requires a coordinated program of progressive care involving multiple clinicians and professionals all working together to design an individualized treatment program for each client. Reductions in staffing don't only affect access to care, they affect the quality of care. We thank Governor Hochul for her efforts to attract and retain state staff through specific programming like the Healthcare Worker Bonus program, Nurses Across New York program, changes to the Tier 6 pension plan and additional operating resources to OMH. But we need to do even more. The state needs to develop a strategy to meet its staffing needs so it can maintain critical services and operational continuity over the long term.

3. Over-reliance on [Mandated] Overtime Hurts Staff and Clients

Instead of hiring appropriate staff and developing strategies to retain these highly sought-after professionals, the state has relied on overtime to meet its staffing needs. In 2020, state employees worked more than 19 million hours of overtime at a cost of over $850 million. Staff at OMH alone worked an annual average of 220 hours of overtime compared to 148 hours in 2011.

The overreliance on overtime to meet long-term staffing needs also has broader implications on the culture of work in OMH and the Office for People with Developmental Disabilities (OPWDD)and the ability of these agencies to attract and retain talent, especially highly-trained workers in high-demand fields (i.e., nurses, psychiatrics, etc.). How many vacancies do these agencies have right now? How many vacant nursing and other positions that require higher education and professional training? We understand that facilities are being forced to reduce capacity and limit operations based on low staffing. Unfortunately, neither agency provides detailed staffing reports to us, nor relays what steps they are taking to meet their staffing needs.

We greatly appreciate the Governor's intention to bring the state workforce back to pre-pandemic staffing levels, but that is not enough to address the state's staffing needs. We thank the Senate and Assembly majorities for passage of bills at the end of session to limit the use of overtime for our nurses and we urge Governor Hochul to sign these important bills.

4. Distractions from Core Mission Leave Staff and Clients Scrambling for Services

The administration at OMH seems more focused on ancillary issues than addressing its core mission of caring for New Yorkers with mental illness in the middle of a public health crisis. In addition to advocating for bed closures, the agency has also engaged in other endeavors to either curtail or expand its jurisdiction into other areas. For example:

a. Transfer of Hutchings Children's Psychiatric Center to SUNY Upstate

In July 2021, OMH and SUNY Upstate announced the transfer of the children's unit at Hutchings Psychiatric Center (HPC) to SUNY Upstate. According to paragraph C of the March 31, 2017, Memorandum of Understanding authorizing the exploration of such transfer, the Commissioner of Mental Health was directed to undertake certain steps prior to proceeding with the transfer, including:

"The Commissioner of Mental Health shall ensure that such evaluation will determine whether Upstate could be used to deliver existing services for children currently provided at Hutchings; expand access to inpatient hospital bed capacity for children and improve coordination and delivery of medical and mental health services for children in Central New York." (Memorandum of Understanding, March 31, 2017)"

HPC is currently funded to provide 23 children's beds. SUNY Upstate has stated it will expand in-patient youth bed capacity to 29 beds. However, 11 of those beds will be reserved to create a new, special unit dedicated to serve youth from across the state with co-occurring diagnoses of mental health issues and developmental disabilities. HPC already has a 30-bed capacity. Are we really qualifying this as an expansion? For the families in the Onondaga, Cayuga, Cortland, Madison, and Oswego county service area, the availability of only 18 youth beds will certainly result in a further cut in services.

This announcement came four years and one pandemic after its authorization. PEF requested a copy of the evaluation for review, but none has been produced to date. More importantly, however, is the fact that this transfer represents a fundamental abdication of OMH's core responsibility to administer and oversee the provision of mental health services to the state's residents. Neither OMH nor SUNY Upstate discussed the treatment plans for these youth with the clinicians who have been rendering their care in some cases for years.

It is also important to note that PEF is not the only advocate sounding the alarm on the failures of our mental health system for New York's children. As you are aware, litigation has been filed against the state by several plaintiffs claiming the state is not meeting its obligations under federal law relative to providing appropriate and accessible non-institutionalized care for youth with mental illness. The complaint, filed on behalf of plaintiffs by the National Health Law Program, Disability Rights New York and Children's Rights, asserts that New York's failure to provide such mental health services violates the Medicaid Act, Title II of the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act. They claim that Medicaid-eligible children do not maintain appropriate access to intensive home and community-based mental health services which subjects them to unnecessary risk of institutionalization. The plaintiffs are children who claim they have been forced in and out of institutions, hospitals and residential facilities due to inadequate alternatives in addressing their mental health problems.

b. Continued Legislative Push to Merge OMH and the Office of Addiction Services and Supports (OASAS)

Around 30% of individuals with mental health issues also suffer from problems associated with addiction and substance abuse. In the 2020 Executive Budget, then-Governor Cuomo advanced a proposal to merge these two entities. The NYS Senate has continued this push. PEF opposes the merger of these agencies for a host of reasons, but more acutely because these two critical agencies will be fighting over a finite pool of resources to deliver services in the event of a merger. PEF fully supports the expansion and integration of any programs and services needed to ensure that any New Yorker who presents himself or herself to an OMH or OASAS facility or program has the ability to get evaluated on-site so that treatment, including the issuance of prescription medication, can be effectuated as soon as practicable. This proposal was first advanced in the 2021 Executive Budget and to date we are unaware of any steps taken by the commissioners of OMH and OASAS to streamline these services for New Yorkers in need

II. Prescriptions For Success

New York cannot hope to address the mental health and addiction epidemic without providing significant additional resources to help New Yorkers access the help they need. The state is seeing an increase in the number of individuals with mental illness, as well as individuals who are afflicted with co-occurring disorders –mental health conditions and developmental disabilities, as well as mental health conditions and addiction issues. Despite this crisis, OMH has not developed enough intensive case managers, state-operated Assertive Community Treatment teams or in-patient capacity to provide needed stabilization services for those experiencing significant mental health and/or addiction issues.

This has resulted in fewer individuals with significant mental health and/or addiction issues getting immediate services and increased interactions between individuals in crisis and law enforcement officers across the state.

We know that the state-operated mental health system functions extremely well despite a chronic lack of resources and staffing. According to OMH's own data, state-operated facilities have higher success rates following inpatient stays compared to their private sector counterpart seven though they admittedly serve individuals with profoundly higher needs.

Expanding capacity is also critical to ensuring the continued safe and successful transition away from incarceration. Research indicates that approximately 50% of incarcerated individuals suffer from mental illness and/or addiction. The state needs to maintain sufficient facilities to accommodate stabilization and addiction services and to provide statewide treatment options at every OMH in-patient facility for those suffering from mental illness and for youth with dual diagnoses of developmental disabilities and mental health issues. We are thankful that the state is requiring enhanced data collection, but PEF was disappointed that the new 9-8-8 system enacted as part of the budget will be operated by a private provider. PEF believes that the state is missing an opportunity to integrate care, calibrate services and track the progress of clients across the spectrum of public and private providers with this new system. The state should use this new system to ensure the integration of data and services available to address these crisis situations by increasing community treatment options and bed stabilization services at each of the state's psychiatric centers to keep clients as close to their families as possible. It is a missed opportunity to advance mental health treatment across the state.

There are many other specific actions that policymakers could and should take to better integrate diagnoses and care, including:

1. Universal On-Site Diagnosis and Treatment: The state needs to hire qualified, licensed staff at each OMH and OASAS facility to enable the immediate, on-site evaluation of all individuals who present for treatment. For those in crisis, this process will facilitate an immediate entry point for care and short-term stabilization or in-patient support, if needed. Developing this capacity will enable an expedited diagnosis of mental health, addiction or co-occurring disorders; facilitate the identification and implementation of immediate treatment plans; and allow for coordination of care between public and private providers of services predicated on the needs of the client.

2. Expand Capacity to Stabilize the Mentally Ill and Establish Regional Programming for Co-Occurring Disorders: The state needs to require each state psychiatric center to expand community-based mental health services and to re-open additional in-patient or short-term stabilization beds to support those suffering from mental illness and to treat those suffering from co-occurring disorders of mental health and addiction issues or mental health issues and developmental disabilities. Diagnoses of co-occurring disorders are on the rise, but state services have not moved fast enough to address this population. Too many New Yorkers, especially youth, are being forced into placements out-of-state to get needed treatment. These resources will help close the service gap for those with mental health issues, address the service needs of those suffering from co-occurring disorders, keep families in as close proximity as possible, support coordinated care between provider agencies (OMH, OPWDD and OASAS) and help gain new insights into the successful identification and treatment of these disorders.

3. Building a Culture of Respect and Collaboration: We are very thankful to have such excellent leadership in the State Legislature and Governor Hochul has certainly set a new, more respectful tone with her state agencies and her employees. However, like all large and diverse operations, there remain certain supervisors in state service who are simply ill-equipped at this time to manage effectively and who operate under the code of conduct established by the former Executive. To that end, we continue to field issues and concerns from members, especially our nurses and health care professionals, who feel that they are being abused and maltreated by certain mid-level managers. We are not indicating that this is a widespread issue, but it is something that requires further consideration and action. PEF has drafted legislation to codify actions in the workplace that constitute "bullying" or "abusive conduct" and this legislation would require that all state employees receive training to identify such conduct with the hope of preventing it in the workplace (S.9437 by Sen. Ramos/A.10367 by Asm. Joyner)

Emily Nolan / Syracuse, New York

Lack of access to mental health services exacerbates the prevalence and continuance of mental health issues. NY state actively contributes to the problem of access to care by preventing qualified mental health professionals from practicing through privileging the licensing of social workers over mental health counselors and creative arts therapists. NY state in the current structure of state statutes and policy limits the ability of creative arts therapists in receiving payments through private health insurance. More access to qualified practitioners provides more services to the public with the ability to rely on one's health insurance inviting more people to seek care.

Sara Taylor / Rochester, New York

I would like to speak about my lived experience navigating the mental health system over the last three years trying to assist my child as featured in this story:
https://www.propublica.org/article/mental-health-beds-new-york-children-disappearing

Courtney Hunter / New York, New York

I am reaching out to provide you with testimony on behalf of Crisis Text Line, a national nonprofit organization headquartered in New York City, which provides free, 24/7, high-quality text-based mental health support and crisis intervention in English and in Spanish.

Anyone in the US can text 741741, or text 443-SUPPORT on WhatsApp. The texter will get an automated response to let them know they've reached Crisis Text Line and ask them to share a bit more about their crisis. Based on the texters first few messages, our texter triage algorithm will determine high-risk texters and move them to the top of the queue, kind of like a mental health emergency room.

We reach high-risk texters in less than a minute and aim to connect all texters with a volunteer Crisis Counselor in less than 5 minutes. The goal of any conversation is to get the texter to a calm, safe place. Sometimes that means providing a resource to further help, and sometimes it just means being there and listening. Every conversation is overseen by a clinical staff Supervisor. They provide support to the Crisis Counselor and help determine the next steps for the texter.

We work with over 130 non-profit, government, and education partners through co-branded text lines. For example, text GOT5 to 741741, like in our New York State Office of Mental Health partnership. We provide partners back with anonymized and aggregated trends about how their line is being used.

In 2021 alone, Crisis Text Line supported more than 1.3 million conversations. Over 74,000 of those conversations were in New York state. Over 50% of those texters from New York self-identified as LGBTQ+ and 62% indicated this was the first time they were accessing mental health support. COVID has taken a significant toll on our mental health, with the majority of conversations focusing on the topics of depression, anxiety and stress.

Please see the attached New York state one-pager for further detail into these aggregated and anonymized data insights. For those in need of mental health support and intervention, please text GOT5 to 741741 to be connected with a crisis counselor in English or Spanish.

John Regan / Albany, New York

As the region's only level one trauma center and Children's Hospital, Albany Medical Center Hospital has provided top quality care since 1849. The mission of Albany Med Health System, comprised of Albany Medical Center Hospital; Saratoga Hospital; Columbia Memorial Health; Glens Falls Hospital; and the Visiting Nurses Association of Albany, is to serve any and all who come through our doors, regardless of their ability to pay. The Bernard and Millie Duker Children's Hospital at Albany Medical Center is dedicated to the well-being of our youngest and most vulnerable residents.

Our dedicated care teams have seen it all, and answered the call. Covid-19 tested us like never before, and it is a test our staff responded to (and continues to respond to) and pass with flying colors. Yet over the past two years there has been another crisis brewing, one that had been quietly growing over the past decades, and which exploded with insidious disbelief during the Covid pandemic: the youth mental health crisis in America.

On any given day, our pediatric emergency department sees desperate parents with nowhere else to turn, with no other options in the region, and with no clear idea where to turn to get help for their child. They have struggled through their children's symptoms of self-harm and suicidal ideation and their sense of hopelessness. These families are devastated by their inability to calm the inner turmoil of their children that they are powerless to stop.

The statistics are sobering. In the past three years the number of children under the age of 18 entering Albany Medical Center Hospital with suicidal ideation has more than doubled. In 2020, just under 150 pediatric cases were admitted, with an average length of stay of just over 2 days. In 2021, in the midst of the Covid-19 pandemic, that number jumped to over 300 with a length of stay of just over 5 days. Thus far, in 2022, from January-May, the first five months of the year have seen over 200 pediatric patients under the age of 18 with suicidal ideation, and an average length of stay of just over 6 days. These numbers represent only those children expressing suicidal thoughts. Teens with eating disorders, drug addiction, self-injurious behaviors, and severe depression are also dramatically increased.

CDC data released in March 2022 back us up:

In 2021, more than a third (37%) of high school students reported they experienced poor mental health during the COVID-19 pandemic, and 44% reported they persistently felt sad or hopeless during the past year. Before the pandemic, mental health was getting worse among high school students, according to the data (https://www.cdc.gov/media/releases/2022/p0331-youth-mental-health-covid-19.html)

Yet while the crisis is growing, resources are shrinking. Albany Med Health System does not have a pediatric in-patient behavioral health unit. Due to the staffing crisis, the only in-patient unit in the region is temporarily closed, and no one realistically expects it to re-open. In the meantime, parents are left to travel hundreds of miles to the nearest facility. Space at these facilities is scarce, and often hard to come by, especially if the child or teen has other medical issues such as COVID or diabetes, for example.

Parents with limited resources are often forced to take time away from paying work; their children are far from home and their support networks.

What happens to these children? They end up in the emergency room, waiting for placement. With no where else to go, this practice is increasing - and no longer unusual for kids to stay several days, even one week in the emergency room, waiting for placement. The current situation in our region is that multiple emergency rooms and holding centers are competing for a shrinking number of psychiatric hospital beds for youth; the use of our Emergency Departments will likely continue to increase. While Albany Med is not a pediatric psychiatric facility, our status as the only academic medical center in northeastern New York means that many families turn to us with nowhere else to go. Our specialists help as they can, but more resources are needed to provide the appropriate level of care.

Patients spending days in the Pediatric Emergency Department require a room, close observation by staff, and specialized care. These inefficiencies in the NY State mental health system waiting for bed placement have resulted in Emergency Departments stretching their resources, thus adversely affecting all children's emergency medical and mental health needs within our region. We should also point out that it is not just teenagers, but children as young as 7 or 8 years of age needing mental health treatment.

We, as a society, are failing those who need us most. An entire generation is without the proper resources to ensure their mental health and safety. That should not even be something to be contemplated in 21st Century America. We are better than that.

A more efficient system, with improved mental health access for children, is critically needed: More inpatient hospital beds for pediatrics, more training and staff to serve those patients, and more resources to support their families. We call on State leaders and organizations to work together to problem solve so we can all help our children. We have shown the greatness and power of New York when we mobilized to fight Covid-19. We owe a similar effort to our children's mental health.

It is a mission that drives us every day to excellence. A mission we never will abandon.

Shoshannah Pearlman / New York, New York

I have been a psychiatric nurse practitioner in New York City for more than eight years, and I believe that the shortage of psychiatric services here is due to the irretrievably flawed and often damaging nature of the care we deliver.

I have completed the psychiatric evaluation of at least 2,000 patients and provided ongoing care for at least a thousand, most of them veterans, homeless, and/or disabled, including many heavy users of psychiatric and inpatient services. Although PTSD is common in the vulnerable populations I serve, most mental health care providers rarely recognize or diagnose it. Diagnoses of schizophrenia, schizoaffective disorder, and bipolar disorder are common. However, the majority of patients I have encountered who had previously been diagnosed with the latter conditions did not have them. They were misdiagnosed partly so that services could be billed arbitrarily, and partly because of ignorance about the profound effects and debilitating symptoms of their trauma. Misdiagnosed or not, many of these patients have experienced psychiatric treatment as coercive or punitive, and have seldom received treatment that did not carry a heavy cost.

Patients in a psychiatric hospital or hospital floor are routinely given medications in high doses that are only meant to stabilize acute episodes of schizophrenia, schizoaffective or bipolar disorder, after which their regimen is supposed to be adjusted to maintenance doses of tolerable medications. This adjustment seldom happens, partly because the duration of hospitalization – once again, driven primarily by billing considerations – is too short, and partly because outpatient providers seldom engage in this collaboration with the patient. Faced with a choice between going untreated or experiencing constant sedation, cognitive impairment, extreme weight gain, and loss of sexual function caused by medications intended to treat conditions many of them do not have, patients stop taking their medication, re-experience acute symptoms, and return to the hospital. While there, they are deprived of their privacy, their dignity, and their basic human need for meaningful activity. When they display the symptoms that brought them to the hospital, they are physically restrained, which can cause injuries that usually go untreated, since medical needs are generally ignored in psychiatric settings. The side effects I described are avoidable, either by switching medications, or by adding others to counteract the side effects, but this seldom happens, since their autonomy, longevity, and quality of life are considered acceptable casualties of their mental illness. Instead, if the cycle repeats itself often enough, the patient is court-mandated to take the same medication. These patients are known as "frequent flyers" by hospital staff, and they are largely the reason there is a shortage of beds in psychiatric hospitals, even though almost no one actually wants to go there. If they received care in the hospital that they experienced as such, they might not need to return so often and their beds would be available to others in need.

Those who say our mental health system is broken are mistaken. In fact, it functions extremely well, but not for the welfare of the people in its charge. Our system is not designed to support patients as they recover, regain their independence, and resume their lives. It is designed to sustain itself as machinery that provides indefinitely for people whose dependence on the system is caused as much by the treatment they receive as by their original illness.

Jeffery Berman / New York, New York

I. Background: How Public Misperceptions and Fearmongering Have Historically Driven Bad Policy for Those with Metal Health Challenges.

My name is Jeffrey Berman. I am an attorney with the Legal Aid Society's Criminal Defense Practice in New York County, and member of the Treatment Not Jail Coalition. I offer this testimony in both capacities to discuss why we need to end our reliance on mass incarceration and involuntary commitment as a solution to our public health crisis. One of the most crucial steps to realigning our priorities to end the revolving door of mass incarceration is to legislate mental health courts throughout New York though the Treatment Not Jail Act (S.2881B-Ramos / A.8524A-Forrest)

I have served as a public defender with the Legal Aid Society for almost 25 years and as the MICA ("Mentally Ill and Chemically Addicted") Project Attorney since 2014. In my position, I serve as the primary resource to attorneys in my office who are advocating for treatment as opposed to incarceration for clients who live with a mental health diagnosis and struggle with substance dependence. In my two and a half decades of practice I have seen countless members of our community, good people who have crises of mental health or substance use or both, sent to jail or prison when what they needed and what was warranted was treatment. As public defenders in NYC, we have tragically witnessed the deaths of countless human beings who might be alive today had they been offered appropriate treatment. I have witnessed too many clients who were denied the opportunity to engage in a treatment court then reach a crisis point that leads them to prison from where they emerge worse off and are potentially rearrested for more serious charges. This revolving door, which includes a reliance on continual, ineffective and costly inpatient psychiatric admissions, harms not only these individuals, but also other members of the community.

Too often, people buy into the false narrative that incarcerating members of our community who are involved in the criminal legal system makes others in our community safer. These narratives prey on our community's fears by repeating this fallacy over and over. However, a robust body of research analyzing the impact of incarceration -in New York and nationwide -indicates that being in jail and prison makes someone more likely to re-offend. The reasons for this are not hard to identify. Incarceration is incredibly traumatizing and destabilizing. The people we send to jails and prisons are too often left to languish during their time inside with inadequate mental health treatment and medical care. Moreover, once their period of incarceration ends, these individuals are released without stable housing, medical care, mental health services or rehabilitation systems in place. These individuals are then expected to gain employment, housing and benefits while navigating the adverse collateral consequences that accompany a criminal conviction. This increases risks for substance use, exacerbated and untreated mental health conditions, psychiatric hospitalizations, and inevitably, further involvement with the criminal legal system - all at the expense of public safety.

Meanwhile, the data show that people who successfully complete mental health or drug diversion courts, should they be lucky enough to be eligible for them or accepted into one, have a significantly lower rate of recidivism. Moreover, diversion is proven to be significantly more cost-efficient than incarceration. While New York City spends $556,539 per year to incarcerate just one person in its jail system, the New York State Office of Court Administration reports that every $1 invested in treatment courts yields $2.21 in savings. In short, investing in mental health courts, community treatment and housing is a far more cost-effective use of state resources than incarceration.

Why do so many people embrace the false narrative that incarceration protects our communities? Many wrongly believe that people with a mental illness are more likely to commit violent acts. The truth is that these individuals are no more likely than the general public to engage in acts of violence, and in fact, are far more likely to be the victims, rather than the perpetrators of violence. Unfortunately for the thousands of justice-involved New Yorkers seeking admission into a mental health court, this misperception often precludes them from accessing needed treatment, which continues the vicious cycle of further destabilization and trauma, an increase in recidivism, and a decrease in protecting our communities.

Many also wrongly assume that individuals facing "violent" charges or who have prior "violent" convictions are less likely to succeed with diversion. Yet studies consistently prove that people charged with violent crimes are just as likely to succeed and rehabilitate in a problem-solving court as those charged with non-violent crimes. Tragically, the result of treatment courts relying on this false information is that many do not accept the motivated, willing and ready would-be participants who are otherwise eligible but for a prior violent conviction.

II. The Limited Current Treatment Court Options for People Charged With Crimes Who Suffer From Underlying Mental Health Issues.

Public safety is something we all care about, no matter our race, ethnicity, socioeconomic status, geographic location or political persuasion. But if we are going to improve public safety, then we must amend the existing Judicial Diversion statute and extend treatment court opportunities to those who have underlying mental health challenges.

The Treatment Not Jail Act does just that by building on and significantly expanding an existing Judicial Diversion statute, which was originally passed in 2009 by Senate Republicans through the budget process. This landmark legislation created drug courts in New York State via Criminal Procedure Law Article 216. Judicial Diversion is currently the only law that permits judges to offer court-mandated treatment to people with substance use disorders as an alternative to incarceration independent of the prosecutor. Thirteen years later, it is clear that the current law is woefully deficient in several respects. First, currently this statute limits eligibility to only a very narrow and arbitrary list of offenses –all of which are low-level non-violent drug and theft-related charges. Second, the statute is primarily concerned with addressing underlying substance use or alcoholism disorders. Thus, even when a person is otherwise eligible, drug courts often reject people with serious mental health conditions or intellectual or developmental disabilities because "substance use" is not the primary diagnosis. Consequently, those with underlying mental health issues are often excluded from any treatment court opportunities, and instead are sent to jail or prison, where upon their release, they are without supports, without health care, and without a home –again, all of which can lead to drug use, psychiatric decompensation and hospitalization, and ultimately, re-offending.

CPL Article 216 was designed and currently operates to address substance use and alcoholism issues exclusively. However, there is no analogous diversion court statute for mental health issues, even though mental health issues are as prominent in the criminal legal system and are indeed widely prevalent in our society. One in five New Yorkers have a mental health diagnosis and roughly half of the New York City jail population is recommended to mental health treatment (though few receive it).

In the absence of statutory authority permitting treatment courts for those with underlying mental health issues, some District Attorney offices and courts throughout the state have collaborated to create ad hoc mental health courts. However, because prosecutors have the gatekeeping power to exclude whomever they wish, access to these courts remains unevenly and minimally applied. In addition to rejecting mental health court applicants due to the person's history or underlying charges, prosecutors often refuse to accept people diagnosed only with intellectual disabilities, developmental disabilities, traumatic brain injuries, neurological disorders and personality disorders -even when the criminal charges are directly related to their disability or impairment.

To be clear, because there is no legislation authorizing mental health courts, politically appointed or lawfully elected judges have no power or discretion in deciding whether to admit a deserving person into these courts. Rather, line prosecutors without clinical experience are empowered. As a result, the participation rates in such makeshift courts are abysmal. Statewide, there are only 30 mental health courts in existence serving only 140 participants.

Meanwhile, despite efforts to shrink New York's prison population, its infrastructure remains one of the largest in the country. As of 2021, more than 40,000 New Yorkers are behind bars and another 337,000 have spent time in prison at some point in their lives; three-quarters of them are people of color. This is a shameful statistic.

The result is that many of our fellow New Yorkers who have been failed by health care, education, housing, and child welfare systems throughout their lives are disposed of in jail or prison, released back into their communities without a home, without supports and without health care. This creates a diabolical catch-22 where the fear-mongers who push for re-incarceration are creating the very conditions that bring about recidivism. This is not protecting public safety.

III. The Treatment Not Jail Act (S.2881B-Ramos / A.8524A-Forrest) –Legislation That Would Expand Access to Treatment Courts for Those with Underlying Mental Health Challenges

We demand an end to this cruel, ineffective, and financially irrational system and call for "The Treatment Not Jail Act" (S.2881B-Ramos / A.8524A-Forrest). This legislation creates meaningful off-ramps from the carceral system, while increasing opportunities for robust community-based substance use and mental health care services for those who need it and the protection of society.

The Treatment Not Jail Act would expand existing Criminal Procedure Law 216 to permit treatment courts to accept people with mental health diagnoses, intellectual disabilities and other disorders that impair their functioning in society and leads to criminal legal system involvement. The bill grants judges the discretion to order diversion for any criminal charge and subsequently dismiss or reduce them without the requirement of an up-front plea, thus protecting people from the collateral consequences of a conviction that would have otherwise been vacated. Such consequences include barriers to employment, licensing, housing, education and immigration—all of which foster instability and ultimately recidivism. The bill guarantees due process protections for participants so they cannot be remanded summarily to jail without evidentiary findings. Finally, the bill pivots away from the overly restrictive and arbitrary charge exclusions that currently limit the pool of applicants for diversion court.

The Treatment Not Jail Act understands that most people who enter the criminal legal system are often victims of lifelong racial and economic injustice, including a lack of access to health care, stable housing, and education. Under the legislation proposed in the Treatment Not Jail Act, a prosecutor cannot summarily decide that someone's life is not worth saving and categorically deny their attempts to enter treatment court. Moreover, in the treatment court model proposed here, a participant's humanity is at all times recognized and participants are treated with dignity and respect. They are given the chance to get well and thrive in the community –ours and their communities –and thus maintain connections to family and friends. Finally, those who complete the court-mandated treatment program will emerge without a criminal conviction and without a sentence of incarceration, thus being spared from the inevitable stigma and trauma that would otherwise have thwarted their ability to procure stable housing, employment, and proper mental health and medical care. As a result, our communities benefit and flourish because the individual in need received treatment, not jail.

We hope the Attorney General will join the growing, widespread support for this important legislation and become a vocal proponent of the Treatment Not Jails Act.

Nadia Chait / New York, New York

I'm Nadia Chait, Director of Policy & Advocacy for the Coalition for Behavioral Health. The Coalition represents over 100 community-based mental health and substance use providers, who collectively serve over 500,000 New Yorkers annually. New York City is facing a behavioral health crisis. Over the past two years, there has been a surge in the demand for behavioral health services. Since 2020, two out of every five New Yorkers reported poor mental health, and rates of anxiety and depression have drastically increased. Almost 7,000 children in New York State have lost a parent or caregiver due to the pandemic and the Surgeon General declared a youth mental health crisis. New York City saw a 39% increase in the overdose death rate in 2020 from 2019, a catastrophic number that shows the speed with which this crisis is worsening. iiiWhile the pandemic contributed to this crisis, the mental health system was unprepared for an influx in demand, due to decades of insufficient funding and cuts to essential programs. Many agencies currently have waitlists for services, and some have paused intakes or temporarily closed programs due to inadequate staff capacity. Although our testimony today will focus on the difficulty of accessing inpatient service, it is important to note that we do not have sufficient capacity for community services either. To resolve this crisis will take both immediate and longer-term actions. Mental health providers, whether in the community or at a hospital, face many of the same challenges.

Lack of Insurance Coverage Impedes Access to Care

For decades, Medicaid rates have failed to cover the cost of care, leaving both hospitals and community providers struggling to fund needed services. For commercial insurance, parity does not exist. Although state and federal laws have improved coverage for mental health care for those with commercial insurance, coverage remains substantially more limited than for physical health. Commercial insurance companies often impose treatment limits on mental health care that do not exist for physical health. Insurers also pay incredibly low rates for mental health care, with commercial insurers paying about half of the already too low Medicaid rates. For comparison, on the physical health side, insurers typically pay substantially more than the Medicaid Rate. Because funding is inadequate, mental health services are often on the chopping block. New York has lost significant inpatient psychiatric bed capacity over the last two decades, with NYC experiencing the greatest decrease.

Staffing Crisis

Across mental health settings, there is a massive staffing shortage. Prior to the pandemic, providers were already short-staffed. However, the impact of the pandemic on our workforce has been devastating. Many staff experienced burn out, as they worked long hours to support New Yorkers while experiencing their own grief, loss and anxiety. Additionally, competition for staff has risen, due to a massive increase in for-profit behavioral health start-ups. The chronic underfunding of the public mental health system means that providers cannot compete with the salaries of entities with millions of venture capital dollars. This has resulted in a shift of the mental health workforce from caring for some of those with the most acute needs to caring for those with less acute needs. The demand for services has also increased significantly, requiring a larger workforce than the mental health sector has ever had. Providers have been unable to expand services to meet this need, as there simply are not enough qualified mental health professionals to hire. This impacts both the community providers and hospitals. Without enough staff, it is not possible to provide the care that New Yorkers need.

Improve Admission Process and Ensure Appropriate Discharge

The inpatient psychiatric units at acute care hospitals serve a crucial function within the mental health system, stabilizing individuals who need a higher degree of treatment than can be provided in the community. Our members are community providers. They do not operate hospitals, and they are committed to keeping individuals with mental illness integrated in the community. However, just as there are times when a physical illness becomes acute and requires inpatient care, there

are times when a psychiatric condition requires inpatient care. This can occur when an individual is actively suicidal, when an individual is making violent threats toward others, or other situations where an individual's symptoms have worsened to such a degree that hospitalization is required. When this happens, community providers work with their client to arrange hospitalization (either voluntary or involuntary), by bringing the client to the emergency department.

» Ease Admissions by Increasing Communication Between Hospitals & Community Providers: our members bring individuals to emergency departments (EDs) and Comprehensive Psychiatric Emergency Programs (CPEPs) to obtain admission into the psychiatric unit. Currently, communication between providers and hospitals is often limited, which can result in individuals not being admitted when it is necessary.

» Admission Process at EDs: Hospitals will observe an individual in the ED to determine if hospitalization is necessary. However, hospitals often ignore the expertise and information from the community provider. The community provider has been working with the client for months or years and has a significant amount of knowledge of the client's disease. Hospitals do not listen to this, and make a snap judgement based on a short analysis of the client. EDs will often observe a client for only a few hours before discharging them, never admitting the client to an inpatient unit at all.

» Admission Process at CPEPs: Hospitals with CPEPs are better equipped to evaluate individuals with psychiatric disorders. Our providers report that CPEPs will often observe individuals for longer, which is more likely to result in an admission. However, even CPEPs generally fail to acknowledge the expertise of community providers, ignoring input from those who are most familiar with the client's condition.

Some Hospitals Don't Admit Dangerous Clients: In some particularly egregious instances, our members report that hospitals have told them a client is "too dangerous" for an inpatient psychiatric hospitalization. For individuals experiencing acute mental health systems that result in violent thoughts or behavior, it is critical that hospitals have the ability to stabilize these individuals. Community providers cannot offer the intensity of services needed to someone whose illness is at such an acute point. No hospital should turn a client away for this reason.

» Increase Length of Stay to Better Stabilize Individuals: When an individual is admitted to an inpatient unit, the admission is often too short to stabilize the individual. It takes time to test out new medications, to adjust medication dosages, and for the impact of new therapies to show results. Psychotropic medications often take a couple of weeks before the results are fully apparent. Hospitals will often only admit individuals for a couple of days, which is too short to effectively stabilize an individual. Insurance companies, including Medicaid managed care, put significant pressure on hospitals to discharge individuals. Community providers find that hospital staff, including social workers and doctors, are unavailable to communicate with during hospitalization stays, an issue that is certainly complicated by staffing shortages. Hospitals sometimes discharge individuals at the first sign of improvement, before the person is stabilized. When clients are discharged too early back to housing programs, it impacts not only their own care, but also harms the therapeutic community for their roommates.

» Improve Discharge Planning: when an individual is discharged from an inpatient unit, it is critical that there be robust discharge planning between the hospital and the community provider. This ensures that the community provider knows the discharge is happening, so they can immediately reconnect with the client and seamlessly transition the client back to community services. With discharge planning, community providers learn of medication and other treatment changes, so they can continue these changes in the community. For residential programs, such as supportive housing, if a program does not know that the client has been discharged, they won't know to be concerned for the client if they have not returned to the residence. Collaborative discharge planning between the community provider and the hospital is essential to ensure that the individual receives the services they need in the community. These are some of the challenges our members have faced with discharge planning:

» Staffing shortages for both community providers and hospitals can make communication around discharge challenging. Hospital staff do not return phone calls for discharge conversations, so community providers are not able to put in place the additional supports required for an individual to remain stable in the community.

» Hospitals are often unwilling/resistant to applications for ACT or AOT, even when recommended by the community provider. For clients with a lot of hospitalizations and non-compliance with treatment, this is often the best option for clients, and hospitals should work with community providers to apply for these services.

» Hospitals do not always notify community providers at all when a client is discharged. Particularly if a client is discharged after business hours, the community provider is often not informed until the following day.

It is critical to improve the admission and discharge process for inpatient psychiatric stays. Community providers expertise must be incorporated. Individuals need to be admitted for long enough stays to actually stabilize. Community providers have to be engaged in discharge planning. To truly meet the needs of New Yorkers, robust efforts must be made to solve the staffing crisis, which will result in increased access to care and better collaboration among providers. New Yorkers experiencing an acute mental health crisis deserve a robust system that is available to meet their needs in a coordinated fashion.

Alice Bufkin / New York, New York

Thank you for this opportunity to provide public comments at this important hearing on access to mental health care for people with serious mental illness in New York State. I am Alice Bufkin, Associate Executive Director of Policy and Advocacy for Citizens' Committee for Children of New York.

Since 1944, CCC has served as an independent, multi-issue child advocacy organization dedicated to ensuring that every New York child is healthy, housed, educated, and safe. CCC does not accept or receive public resources, provide direct services, or represent a sector or workforce. We document the facts, engage, and mobilize New Yorkers, and advocate for New York City's children.

CCC also coordinates the Healthy Minds, Healthy Kids Campaign, a statewide coalition of behavioral health providers, advocates, and family organizations that has joined together to create the public and political will necessary to ensure that all children and adolescents in New York receive the high-quality behavioral health services they need.

Addressing the children's behavioral health crisis

Long before COVID-19 arrived, children were facing a behavioral health crisis, driven by chronic underinvestment in the children's behavioral health system, deeply inadequate reimbursement rates, and a focus on crisis intervention rather than the full continuum of behavioral supports for children and their families. Even prior to the pandemic, death by suicide was the second leading cause of death for children 15-19 and the third leading cause of death for children 5-14 statewide, and approximately half of children who needed behavioral health services were unable to access them.

COVID-19 entered this dramatically under-resourced system to devastating effect. More than 7,000 children have lost a parent or caregiver to COVID-19 statewide, and approximately 325,000 children were thrust into or near poverty. Children are entering their third year of profound personal loss, economic instability, housing and food insecurity, and unprecedented educational disruption.

In New York and across the country, the pandemic has led to declines in critical mental health screenings and access to services, even as rates of anxiety, depression, substance use, and suicidal ideation have risen. Children are experiencing serious emotional distress yet have been unable to access adequate primary and preventive services, resulting in stark increases of psychiatric symptomatology and hospitalizations.ivThis has created a perfect storm that is impacting all

children, and disproportionately impacting low-income communities and families of color. The American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association have all declared a national state of emergency in child and adolescent mental health.

These new and long-standing issues have contributed to the rise of serious mental illness among youth, and the lack of adequate resources to serve them requires urgent action from the state.

The closure of Residential Treatment Facilities and psychiatric inpatient beds

Over the past 10 years, the number of residential treatment facility beds for children and adolescents has declined dramatically, from 554 in 2012 to 274 in 2022–a 50% reduction. Since 2014, the state has also shut down nearly a third of its state-run psychiatric hospital beds for children and adolescents.

The State began purposefully closing state-run psychiatric hospital beds, justifying these closures by claiming that children's behavioral health needs would be fulfilled by new community-based services arising from the redesign of children's Medicaid. Yet these services never fully materialized. In fact, as discussed further below, the State may now be serving fewer children with a less robust array of services than prior to redesign. Chronically low rates –among other issues –have driven the steep decline in the number of Residential Treatment Facilities.

As a result, children with acute behavioral health needs are not only struggling to find outpatient services; when their needs escalate due to lack of care, their families are forced onto long waitlists for residential treatment services. In turn, these children frequently cycle in and out of hospitals, emergency rooms, and, too often, handcuffs and police intervention.

RTFs and psychiatric hospitals are intended as last resorts for children who have intensive needs that have not been met in clinics or communities. Ideally, all young people in need of behavioral health supports would receive these services early and upstream, preventing the need for more intensive services. In reality, children in New York are not receiving the outpatient care they need early, nor are they able to access the residential services that families desperately seek after all other options have failed.

The issues plaguing the children's behavioral health system go far deeper than residential treatment beds; and, in fact, any conversation about acute services must begin with considering the holistic needs of children and families. The remainder of this testimony touches on key areas that contribute to the broader system driving children into the need for intensive care.

However, there are specific barriers contributing to the widespread closure of RTF beds. Thankfully, the FY23 State Budget included significant and critically needed investments in the children's behavioral system, including a 5.4% COLA for many human services workers, bonuses for mental health workers, $7.5 million to increase rates for children's RTFs, and a number of rate increases. However, many of these investments will not go into effect in time to prevent further loss of providers. New York must use existing resources to implement any proposed rate increases now to prevent further closures.

More fundamentally, it is abundantly clear that rates are and have been insufficient to maintain capacity. The State must undergo a rate methodology analysis and a study of bed needs in order to address the chronic issues affecting RTFs.

Families also suffer when they have waited for months to access RTF services, only to find that the facility they are waiting for is closing. For those receiving services and experiencing a closure, the fear of finding alternative care can be excruciating. This thrusts families back into a painful and life-altering process of navigating the byzantine behavioral health system, all while fearing they may be too late to help their child. When a provider files an application to close beds or services, the State must provide interim supports to enable services to continue operating until an alternative provider is identified and contracted to provide services.

Moreover, the current measure of "network adequacy" is deeply flawed and disconnected from the reality of a child's life. The state should mandate a change in the calculation of network adequacy, articulating that a network is not adequate if waiting periods to access care are longer than three weeks. Additionally, the State should mandate that health plans that fail the network adequacy test be required to pay the government rate or higher to providers to keep them in the network until alternative providers are available.

Medicaid Redesign promised to deliver improved services to more children – it has done the opposite

The state has justified the closure of child and adolescent residential facilities by claiming new community-based services through Medicaid transformation would reduce or eliminate the need for out-of-home care. In an ideal world, the State would sufficiently invest in community-based and clinical outpatient services, providing all children with the services they need early, before needs become more complex and families turn to inpatient and residential settings. In reality, the State has failed to achieve its goals, and children continue to experience serious and complex mental health needs that only escalate the longer they do not receive appropriate treatment.

More than ten years ago, New York formed the Medicaid Redesign Team with the goal of utilizing a managed care delivery system to improve care for individuals with behavioral health needs and those needing long-term services in homes and communities. Per a recent report by the Rand Corporation providing an independent evaluation of New York's Children's Redesign, "Specific goals include improved clinical and recovery health outcomes; timely access to health care services during childhood so as to improve functioning and reduce health care needs in adulthood; improved integration of care that is commonly fragmented across behavioral health, general medical, and community support systems; and increased capacity of provider networks to deliver community-based recovery-oriented services and supports." Since its initial roll out in 2019, it is difficult to say that any of these goals have been achieved, and in many areas the state is moving backwards.

From the beginning, a lack of commitment from elected State leaders hindered the success of redesign. There followed a series of delays in implementation, which helped create confusion and erode trust in the new services among both providers and families. The transition to managed care created new administrative complexities, even as providers were dealing with a high volume of reimbursement claim denials. The combination of low rates and an expectation to cover broad geographic areas contributed to high volumes of providers de-designating, further reducing the pool of providers able to offer services, particularly specialty services.

As a result, the children's system is inadequately serving children and families. The new service array is serving only a fraction of the children it promised to serve and is providing access to a less robust service array; meanwhile, implementation has added innumerable barriers that have resulted in many eligible children unable to receive services at all. In 2017, OMH estimated that approximately 200,000 children would be eligible for new Children and Family Treatment and Support Services. As of October 2020, only 8,000 children were receiving CFTSS.

The figures for HCBS are equally dire. Before consolidation, the number of children enrolled in HCBS was around 7,100. This figure dropped to 6,215 after implementation of the children's HCBS, before rising to 7,926 by February 2021.Even the slight uptick in enrollment is misleading, however, as there was only an increase of 570 claims between April 2020 and January 2021. And significantly, the number of enrolled children falls dramatically short of the state's original estimate that 65,000 children would be eligible for new HCBS services.

In addition, when care coordination was removed from the HCBS array and added in a less intensive form as a State Plan service, it was estimated that over 170,000 children and adolescents would access the service. Barely 30,000 actually were as of September 2021.

The established rates were based on high caseloads which never materialized, in large part due to slow rollout and flaws in program design. How could providers possibly continuously and adequately supply services if the rates developed for the services were based upon wildly inaccurate actuarial assumptions?

Moreover, the array of services being provided through HCBS is far less robust than what was provided before the transition. Though it is difficult to quantify this difference given that the old waiver and new waiver elude "apples to apples" comparisons, anecdotally the OMH waiver and B2H waiver provided a more robust package of services, including care management, respite, family peer services, and counseling. As well-documented in the Rand Corporation's interim report, the replacement of care management with care coordination through Health Homes has detrimentally reduced the intensity of care management for families. The system has moved from a more centralized, supportive approach to care management to a more fragmented approach, where families have had to consult with multiple individuals to receive supportive services. The combination of increased paperwork, complicated processes, and increased caseloads has resulted in families dropping out or settling for a lower level of care that is less complicated to navigate.

In the face of HCBS's shortcomings, more and more providers report relying on CFTSS services to support higher-needs children who could not get care through HCBS. But CFTSS was never intended to serve high-acuity children –those services were intended to be preventive, skill-building care. CFTSS is not designed to meet this higher level of need, nor are CFTSS providers equipped to provide them. The challenges of HCBS are thus not only denying services to children with more acute needs, but also putting unsustainable strain on CFTSS.

Since 2012, OMH has closed 270 RTF beds for children –more than half of its capacity. It has also closed roughly 150 state run psychiatric beds for children and adolescents. We believe that more upstream services should be provided to keep children from needing intensive inpatient care. But the reduction in RTF beds has not been offset by an increase in funding for community services, and it is increasingly clear that the new combination of Health Home Care management, HCBS and CFTSS –as they currently function –are not meeting the needs of the children and families they were intended to serve.

Creating a functioning children's behavioral health system is complex and challenging, and we recognize that enormous effort has been spent on this mission for years. However, we feel it is time for the State to take stock of the successes and failures of children's redesign, and re-engage families, providers, and other stakeholders in an evaluation of the program and the development of an alternative. This effort must not only compare the quality and amount of services children received prior to and after the transition, but re-commit to creating a system that meets the needs of all children and families in the state.

New York Has an Opportunity to Improve Outcomes for Children

Importantly, we know the types of services that can help children and families thrive. New York's clinicians, community-based providers, and other mental health professionals have been providing innovative services to children for years, from preventive care to care for children with the most complex needs.

Investments in the Fiscal Year 2023 Budget took a significant and welcome step towards addressing the chronic underfunding of the system. These investments included but were not limited to a Cost of Living Adjustment, workforce bonuses, investments in school-based mental health services and the HealthySteps program, and enhancements to inpatient psychiatric care, children's RTFs, and a permanent 5% rate increase for outpatient Article 31 clinics.

We are enormously grateful for these investments, and believe they are an important foundation for strengthening the children's behavioral health system. That said, New York's behavioral health system was starting at a deep deficit, and has an enormous amount of ground to cover. We must create a system that serves children across the continuum –from young adults to the youngest New Yorkers; from preventive services to acute needs; in schools, homes, communities, and clinics. We cannot talk about children's serious mental health needs without discussing all the many failures –and failed opportunities –that could have prevented reliance of out-of-home services if adequately resourced. We ask that you consider the breadth of behavioral health needs for children, including but not limited to:

Increase overall behavioral health funding for children and families.

Historically, children's services have received only a fraction of the overall behavioral health investments in the state. For instance, despite comprising 40% of the Medicaid population, only approximately 10%of Medicaid expenses are for children. By failing to invest in children, the State is failing to invest in the preventive services that help address behavioral health needs early, before children grow into adults with more complex needs that require more intense and costly services to address. Only by investing in supports for the youngest New Yorkers can our state break the cycle of behavioral health crisis that turns struggling children into adults without recourse for care or adequate support.

Address chronic workforce shortages

The frightening reality in New York is that there are 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, the state must identify strategies to increase the number of multilingual providers and providers of color.

The state must invest in recruitment and retention strategies designed to foster a workforce that is representative of the population it is serving. Among these strategies are efforts to reduce educational debt of new practitioners, establishing loan forgiveness programs and scholarships, and providing college credit for on-the-job experience and learning. We also urge greater investments in youth and family peers, who are often rooted in the communities they serve, but are significantly underpaid. Peers can serve a vital role in supporting families as they await a full array of services, and should be better supported and integrated into the broader system of care.

Address Deeply Inadequate Rates that Have Harmed Family Access to Care

A history of inadequate rates is at the root of the shortage of behavioral health providers for children. This shortage has driven children onto waitlists and into emergency rooms, where they are discharged into communities unable to provide them with the critical ongoing and preventive services they need. Given the extent of the workforce shortage in New York, a primary workforce strategy must be to increase reimbursement rates in Medicaid, commercial insurance, and State contracts so that providers receive adequate compensation to enter and remain in the field.

As part of this effort, the State must reform rate methodologies to help ensure rates are sufficient to support much-needed capacity for children's behavioral health needs, and conduct an annual assessment of the viability of clinical rates. Current rates for Clinics, Residential Treatment Facilities, Home-Based Crisis Intervention, CFTSS, and Home and Community-Based Services are all based on faulty or outdated methodology. The state will never develop the capacity to serve all children if rates are not aligned with the reality of the cost of service delivery.

Hold health plans accountable for meeting contractual obligations and enforce mental health parity laws on behalf of children and youth.

Despite federal and state mental health parity laws, families in New York continue to be denied equal access to behavioral health services, ranging from unnecessary pre-authorizations for treatment, to high out-of-pocket payments, to severe network inadequacy. New York must enforce compliance with federal and state mental health parity requirements, including by strengthening fines, expediting enforcement of parity violations, and requiring that these fines be reinvested into the behavioral health system.

Conclusion

This testimony cannot adequately convey the desperation families face every day when they are unable to find the behavioral health services their children need, and day after day fear for how their children's needs with worsen the longer they go without care. We appreciate the Attorney General's office for holding this hearing, and hope it will drive action to address the deep challenges facing the children's behavioral health system more broadly.

Tamara Begel / South Setauket, New York

My child is actually one of the "lucky" ones. He is alive today and is now receiving the mental health care that he needed–but that is only because as an advocate, I knew the system intimately and used all of my skills to obtain those important services for him. Even then, however, despite my skills, experience, and best efforts, it took more than six months just to find a treating psychiatrist who accepted my insurance (Aetna)--and that was only our first of many hurdles.

The psychologist was important in my son obtaining a hospital bed, when needed. In fact, when my son was 9 years old, at his first visit to the psychiatric ER–CPEP, in Stony Brook–they did not admit him, even after he tried to hang himself. It took months of further decompensation and four additional psych ER visits–along with phone calls from his psychiatrist–for my son to get admitted to a hospital so that he could begin to receive the therapeutic help he required. Even then, my son waited days in the CPEP before actually getting admitted to a bed on the hospital floor. This wait for help is not considered extraordinary, it is in fact standard operating procedure for the most seriously mentally ill children in New York–and since Covid, my understanding is that these conditions have only worsened.

During the most recent of his four inpatient hospitalizations, my son again spent several days in CPEP in Stony Brook before he was transferred to South Oaks Hospital in Amityville. There, on the second day of hospitalization, it was agreed that he should instead be inpatient at the longer-term Sagamore Hospital in Dix Hills and an application was filled out and sent there. In the interim, however, my child spent two months in South Oaks waiting for a bed. Put bluntly: South Oaks is not built for hospitalizations this long for patients as acute as my child.

A majority of those weeks waiting were spent on lockdown, without family visits, because Covid was spreading through his units. During this time, my child was hit by other patients many times and even punched in the face. Please remember: my child was in the hospital because he was in crisis and needed health care, and this was his experience. Events like this occurred daily. As my child said to me, "putting a bunch of kids together for days on end in a small space without much to do, and little time outside playing isn't therapeutic."

Finally, I convinced nurse managers to move my son to the teen unit, since his birthday was the following day. They assured me they would obtain the necessary permission and then move him so that he would be safe. However, I hadn't even walked back into my house from that conversation when I received another call from the nursing staff informing me that my 12-year-old son had been kicked in the groin. He was moved a few hours after this incident but the bullying never really stopped. During this interminable two-month wait, my son and/or the staff reported regular events of altercations where he was hit, or kicked, or pitchers of water were dumped on him. Eventually, this escalated to orange juice, which he is allergic to, being dumped on him.

During a rare opportunity when Covid restrictions were lifted and I was able to visit, I observed that a majority of the staff were staying in the hallways and simply looking into the windowed day room where the pediatric patients were spending much of their waking time, even though they had fewer activities than usual to occupy that time. When I inquired about why staff weren't giving the kids access to games and art materials, the staff claimed that, due to covid, nothing could be shared. In this void of organized activities, it didn't actually surprise me that the children often resorted to physical violence.

Bullying and boredom were not the only negative experiences my child had while waiting for treatment, however. I believe that South Oaks Hospital's standard practice is to use both chemical and physical restraint on children too often and with

too great an intensity. My son experienced both during his most-recent stay. Essentially, South Oaks Hospital's response to the trauma my son experienced after being hit by another patient on the floor was to administer both physical and chemical restraints to him.

After this fourth hospitalization, I requested and read through my son's medical records. It immediately became clear to me that in addition to physical restraints, South Oaks had also used varying doses of chemical restraints on my child. This last hospitalization, when because of Covid I was able to visit him least, was the only one that required regular use of chemical and physical restraints. I noticed that some of the doses of chemical restraints were drastically higher than others–one was actually almost twice as high.

But let's also talk about the use of physical restraints: At an earlier visit, I'd observed another patient, in a wheelchair, in restraints. Despite the fact that he was being peaceful, this child was not let out of his restraints. More than once, during my visits, I also overheard nurses threaten children who were fighting with being put in 30-minute restraints. Please note: It is illegal to threaten restraints, and it is also not according to code for them to be restrained for that long unless the individual is fighting the entire time. Once a person calms down, they are supposed to be released from the restraints. My son told me that they only do 30 minute restraints in South Oaks and this seemed to be confirmed when I was told on several occasions that he required restraints. Never was a more minimal time quoted.

In my observation, restraints were not used to this same degree at Sagamore Hospital. My child was given oral Vistaril a few times and maybe a five-minute hold here or there, but I observed a startling difference in chemical and physical restraint use between the two hospitals during this same period of illness for my child.

During his hospitalization and when I wasn't getting sufficient responses from nurse managers or other staff, I called the Justice Center and asked that they look into:

1. Whether all safety protocols were followed for my child since he had been attacked daily by the same resident, and yet staff couldn't keep him safe and
2. If all protocols were followed with regard to the use of physical and chemical restraint.

I waited months for a response from the Justice Center only to find out that they had assigned the hospital to review itself in my matter, and as a result, I would have to obtain my report through them. It has been 15 months.

I appealed to South Oaks, a subsidiary of Northwell, to release the incident reports and the Justice Center report, as is my right under Jonathan's law. They refused, claiming my matter was "not a serious incident." I then appealed to DRNY and OMH by emailing every few weeks and eventually every month.

OMH eventually sent a letter, stating: "According to the incident report filed by South Oaks into our Office's database, the patient was punched in the head and kicked in the groin several times, which clearly meets the definition of an incident... Your conclusion is incorrect as you failed to note the exception found in this statute. Social Service Law §490(2) states: "Notwithstanding another provision of law, except as may be provided by section 33.25 of the mental hygiene law..." MHL §33.25 South Oaks to release records and documents pertaining to allegations and investigations into patient abuse or mistreatment in a facility to a qualified person. Ms. Begel is a qualified person."

The events occurred late March 20201. This letter was sent on 8/30/2021. It is now 6/17/22. I have yet to receive that report. I am told OMH is still working on it and to expect movement soon. Most families do not report abuse, because of a fear of retaliation. Being a member of the Long Island Families Together Legislation Action Committee gave me the confidence that if there was retaliation against my child then there would be a group of individuals willing to callout that abuse of power.

My child spent two months at South Oaks and a majority of his stay was on unit lock down because there was Covid on his floor. Though children in congregate care settings were supposed to be first on the list for covid vaccine's, children in inpatient mental health hospitalization were not. It took State Senator Marrio Mattera directing his lawyer to step up for

my right to vaccinate my son to convince South Oaks, a subsidiary of Northwell Health, to allow in-patient children to be vaccinated. I had to advocate at Sagamore, when my son arrived there as well. Our state must add inpatient children in mental health facilities and hospitals to their pandemic vaccination plans, because they are exposed to drastically more people in their daily life than children on lockdown.

Psychiatric hospital floors are full of patients in need of support, incidents occur, I understand that. At Sagamore Hospital, my child was bitten severely by a patient and was also in one instance grabbed in an illegal hold to the point of bruising by a staff member. At least Sagamore reported those instances to the justice center and gave me the reports. Unlike South Oaks, however, Sagamore refused to give me my child's medical records. Please note: I wasn't requesting treatment notes. Just his medical record and behavioral record. I have not followed up on this yet as I have been focused on obtaining the incident records from South Oaks.

Please know that my son's story is not unique. In parent groups and waiting rooms, I hear the same stories about the same hospitals. My son is now in an RTC in Lake Placid New York, because there are not any that can meet his needs closer to home. My son has been out of my home for over a year and half because we cannot get the mental health services he needs on Long Island.

Why?

» The SPOA providers do not get a living wage. So they are either new at their jobs or disgruntled by the system. They are overworked and underpaid. Many have to hold 2-3full time jobs just to pay the bills. McDonalds employees earn more. As soon as the have enough experience, they move onto higher paying jobs.

» The people who are left have extremely large caseloads that they cannot possibly serve, because positions can't be filled for such low wages.

» The non for profit and for profit companies are not reporting their caseloads and waiting lists. They always claim to be looking for new people to hire.

» The system has crumbled. There is neither oversight nor accountability by the larger agencies. They overwork the case managers and family peer advocates with each member doing the same safety plans over and over.

» However, caseload reporting, waitlist, unfilled positions etc.? Those numbers are not being reported to the public– and our children and their families are suffering as a result.

Let me repeat this: The mental health systems of service on Long Island have crumbled.

Allowing not-for-profit companies and for profit companies to deliver services has failed.

Companies protect their bottom line first and foremost and OMH– who should work to keep these companies accountable,

» does not keep publicly available records on their waiting lists for hospitalizations.

» does not write publicly available reports about how long children wait in ERs to enter acute stabilization Mental Health wards and hospitals.

» does not keep numbers on how longer term, acute-care therapeutic hospitals take to determine eligibility of a patient for their services… let alone how long it takes to admit them.

» does not keep easily accessible numbers that are publicly available for the number of justice center complaints and their finding

» does not ensure that families receive the reports they have a legal right to obtain in atimely matter

» does not enforce a families' rights to review medical records of clients, and the hurdles to receiving those records that families are made to go through

Reporters like Abigail Kramer who wrote about my family are told that the system has lots of beds open and there isn't a backlog. However, the truth has been that during Covid entire floors were closed because of a lack of staffing, and therefore those "open beds" could not be filled.

Yet another hurdle is the access to high acuity long term treatment. Decision makers have closed the residential treatment facilities (or RTFs) on Long Island, and so kids who require a higher level of care are now often placed in lower levels of care that are not equipped to handle them: RTCs, and group homes. I personally know of a child who was staying in one of these group homes and was beaten by his roommate. He now has permanent scars, both emotional and physical.

Coming back around to that first hurdle I mentioned at the start of my testimony: The amount of money that Medicare, insurance, and the state pay for psychiatrists is too low. It doesn't cover practice insurance and living expenses. As a result, most child psychiatrists who are practicing on Long Island have gone to private pay but it is too costly for families to afford this private pay price–where is the parity in mental health care that we have been promised?

This has system-of-care implications: A new, desperately-needed clinic for kids with mental health issues cannot open at Well Life in Coram, because the grant funding the project requires that the psychiatrist must be in person and full time, not via telehealth. The pay they are offerings so low that none of the psychiatrists will take this on full-time, in person. Instead, the money for the project sits in escrow while the children in our region suffer. Kids who have attempted suicide go without psychiatrists for over six months to a year, because those few psychiatrists who do accept insurance are so over-booked, they have no ability to screen new patients. Therapists are also very hard to find.

I know a child who, after months of looking, finally found a psychiatrist who prescribed a medication that requires labs but will not send him for lab work to check levels or adjust it. It takes him going into crisis and then a visit to the ER in order to have a level taken for med changes to happen. His family has been on waiting lists for over a year and still can't find a treating psychiatrist who will do basic adjustments to his medication.

Again, my son was one of the "lucky ones", after five years from the first suicide attempt, he is now receiving the mental and behavioral health care he needs. I found him an RTC, that is Regents approved, trauma-informed, and where every staff member is trained in Autism. This is a needle-in-a-haystack find.

He has been there 5 months and he has another 6 months to a year to go before he returns home. However, I'm already calling providers and begging my way onto home services lists in hopes that services are in place when he does return home. The waiting lists are that long!

We are better off than most, but what do families who don't know the system do? What happens to families who are too afraid of retaliation to report incidents to the Justice Center? Families with suicidal children who are on never-ending waiting lists for services and meds. What happens to the families where both parents work or a single mom is holding down a job and parents multiple kids? New York has to do better!

Allyce Morrissey / Bronx, New York

Good afternoon, my name is Allyce Morrissey and I am 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 1,500 people experiencing homelessness in the Bronx.

Homeless individuals living with mental illness are not inherently dangerous to themselves or others. 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 appear 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 email that he "jeopardize[d] the safety of our staff and other 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 Assisted 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 judgement." 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 911 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 State 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 shortage, 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.

Rachel Fernbach / Garden City, New York

The New York State Psychiatric Association ("NYSPA"), the medical specialty society of nearly 4,000 psychiatrists practicing in New York State and a division of the American Psychiatric Association, thanks New York Attorney General Letitia James for holding this public hearing on the crisis in mental health care in New York State and appreciates the opportunity to submit testimony. NYSPA's goal and mission is to promote quality mental health care in New York State.

NYSPA also wishes to acknowledge and thank Attorney General James for holding insurers and health plans accountable for violations of federal and state mental health parity laws, including the May 2022 recovery of more than $13.6 million on behalf of 20,000 New Yorkers whose mental health claims were denied by UnitedHealthcare. In the words of the Attorney General, we must continue to "... tear down the barriers to healthcare established by insurance companies and hold these companies accountable for failing our communities."

Inpatient Capacity

As part of the planning for a surge of COVID-19 cases in March/April 2020 and in compliance with an Executive Order, more than 400 inpatient psychiatric beds were taken offline in anticipation of need in case of an influx of cases and to maintain ability to perform elective surgeries (see illustration to the right appearing in The Wall Street Journal, October 2020). However, many of these beds went unoccupied and were subsequently repurposed for medical/surgical use, not reopened and/or taken out of commission altogether. NYSPA strongly urges the Attorney General to conduct an investigation to assure that all of these beds are reopened immediately and to hold those institutions accountable for any delay or permanent closure that violates the Public Health Law and Certificate of Need requirements. This action is needed promptly and comes on top of a 2019 estimate published in a white paper by the New York State Nurses Association finding the number of certified inpatient psychiatric beds decreased by 636 between 2000 and 2018 in New York State with two-thirds of the 636 beds lost within New York City. The statistics are more alarming for inpatients beds for children and adolescents.

One of the most notable examples of this is WMCHealth, parent company of HealthAlliance of the Hudson Valley, which eliminated its 60-bed inpatient mental health unit at Mary Avenue hospital campus in Kingston in March 2020 to accommodate the potential COVID-19 surge. According to many reports in the press, including in the Daily Freeman in April 2022, "Although there was never a need for the additional beds, WMCHealth did not reopen its inpatient facility and has since sought to make that closure permanent." There are also similar instances of bed reductions at New York State Presbyterian's Allen Hospital (30-bed psychiatric unit) and Brooklyn Methodist Hospital (two 25-bed psychiatric units).

On May 25, 2021, the Department of Health issued a Dear Administrator letter to hospital chief executive officers (DAL 21-02) directing that previously granted flexibility for construction, modification, expansion, closures or limitations of beds under previous executive orders and or guidance is rescinded. DAL 21-02 stated: Justification must be submitted within 30 days from the date of this letter for any licensed Office of Mental Health (OMH) Article 31 or Office of Addiction Services and Supports (OASAS) Article 32 beds or services must be converted back to their certified use. The justification must include any alternatives that were explored as well as written agreement from OMH and/or the Office of Addiction Services and Supports (OASAS) as appropriate. The space must be currently occupied for purposes related to COVID-19 and the justification must include a description of how the space will continue to be used for COVID-19 related purposes. Emergency Approval requests must continue to be submitted to the appropriate Regional Office for: major construction or modifications; new facilities or locations that are anticipated to be needed for COVID-19 response or surge capacity, and for any changes being made for COVID-19 response or surge capacity that will impact OMH or OASAS services… For any modifications or construction, or changes in beds or services that are anticipated to be permanent or needed beyond 6 months after the end of the State of Emergency, a CON must be submitted within 1 year of the date of this letter. This includes requests for dialysis in nursing homes. In addition, closure plans must continue to be submitted for any closures of sites or services, or changes in beds, that are expected to be permanent.

NYSPA urges the Attorney General to work with the Governor and the Commissioners of Health, Mental Health and Addiction and Support Services to ensure that hospitals are in compliance with the requirements of DAL 21- 02 and the Public Health Law.

NYSPA supports the statements of the Office of Mental Health Commissioner Ann Sullivan, MD, who testified at the Legislature's Mental Hygiene budget hearing on February 14, 2022, stating in part, "Across the state there have been hundreds of beds that closed or migrated due to covid. We are looking to reopen all those beds." New York can ill-afford any of these beds to be permanently eliminated under the guise of COVID-19 needs and purposes as we confront the enormous psychological toll and trauma of the pandemic. from the Centers for Disease Control and Prevention found over 40% of adults in the United States reported struggling with amental health or substance use disorder. The study also showed that almost 11% of respondents had seriously considered suicide in the 30 days prior to survey completion, and the number was significantly higher among 18–24-year-olds (over 25%). In April 2022, NYS Department Health quarterly opioid report finding New York experienced a record increase in overdose deaths in 2020 with average of nearly 12 deaths every day in 2020.

Telehealth

One silver lining throughout the pandemic has been telehealth. Despite the fact that telehealth has been available for quite some time, it was the March 2020 lockdown restrictions due to COVID-19 that prompted exponential growth. This growth was also made possible by statutory and regulatory flexibilities authorized by the Centers for Medicare and Medicaid Services and the New York State Department of Health and Department of Financial Services with respect to covered locations for telehealth and coverage of audio-only telehealth. During that time, mental health and primary care were the most utilized services, with the number of patients receiving virtual mental health treatment increasing 130-fold during the pandemic. A recent report from Athenahealth noted that a year ago, approximately 65% of Americans felt hesitant about the quality of telehealth and 56% did not believe it provided the same level of care as in-person appointments. A year later, all that has changed and almost 88% want to continue using telehealth for non-urgent consultations.

The data from FAIR Health's Monthly Telehealth Regional Tracker demonstrates the acceleration in telehealth since March/April 2020, which 18 months later demonstrates mental health conditions are still by far the top five diagnoses for telehealth accounting for just more than one-third of claims. The data from July and August 2021 n FAIR Health's Monthly Telehealth Regional Tracker shows mental health conditions account for nearly 68% of telehealth claims and provides a breakdown of the top mental health diagnoses on these claims: generalized anxiety disorder, major depressive disorder, adjustment disorders, attention-deficit hyperactivity disorder and post-traumatic stress disorder.

Meanwhile, a survey conducted in spring of 2021 by the American Psychiatric Association found nearly four in ten Americans (38%) used telehealth services to access care with a medical or mental health professional, a 7-percentage point increase from the fall of 2020. More than 80% have used telehealth services since the onset of the pandemic. Sixty-nine percent of the survey respondents utilized video format while 38% used audio-only telehealth. The survey also found 59% of Americans would use telehealth services for mental health, and 43% plan to continue to use telehealth when the pandemic is over. NAMI's 2021 survey found similar results with 83% satisfied with the use of telehealth and notably 79% say telehealth made it easier for them to access care.

New York took an important step to maintain access to telehealth this year as the enacted New York State budget for 2022-2023 included landmark legislation mandating reimbursement parity for coverage of telehealth services, effective April 1, 2022. This legislation requires payment "… on the same basis, at the same rate, and to the same extent the equivalent services… are reimbursed when delivered in person." The parity provisions will apply to the Medicaid program and to all insurers and health plans regulated by the New York State Insurance Law. The legislation requires the Department of Financial Services, in collaboration with the Department of Health, to conduct a study and issue a report by December 31, 2023, evaluating the impact of telehealth reimbursement parity during the first year. As the law currently includes a sunset provision for April 1, 2024, the substance of this report will be a factor in deciding if the law should be extended beyond 2024.

Mental Health Parity

For many years, NYSPA has been advocating for mental health parity – equivalent coverage and reimbursement for the treatment of mental health and substance use disorders. In addition to Timothy's Law, New York's mental health mandate, and the federal Mental Health Parity and Addiction Equity Act, recent legislative successes have allowed New York to make great strides towards full parity implementation. The Behavioral Health Insurance Parity Reforms (BHIPR), a comprehensive overhaul of the New York Insurance Law included in the 2019-20 New York State Budget, mandated coverage for all mental health conditions, substance use disorders and autism spectrum disorders by individual plans, group plans and HMOs. Other recent victories include the Mental Health and Substance Use Disorder Parity Report Act, enacted in 2018, which requires plans to implement formal parity compliance plans along with regular reporting to the state. The advocacy and support of NYSPA was critical in the enactment of these important measures. The continued implementation and enforcement of the parity laws is a critical component in addressing the mental health crisis, which has only been exacerbated by the psychological toll of the COVID-19 public health emergency.

Effective January 1, 2021, the American Medical Association significantly revised the coding and documentation requirements for Office and Outpatient Evaluation and Management Codes (99202-99205 and 99211-99215) contained in CPT. Following these changes, physicians, including psychiatrists, have reported a significant increase in utilization review efforts and activities undertaken by health plans in connection with claims for evaluation and management services. It appears that insurers are not properly implementing the current documentation or coding requirements for E/M. Over the past year and a half, psychiatrists in particular have experienced some of the following: automatic down coding of E/M claims; widespread denial of claims and imposition of pre-payment review; statements that psychiatrists are not permitted to use E/M claims and must instead only use the codes designated for non-physician mental health providers; and the wholly incorrect assertion that a psychiatrist is not qualified or eligible to provide psychoanalysis.

The above examples, if left unchallenged, will have a chilling effect that is likely to spread across the industry. Further, not only will a psychiatrist or practitioner be potentially disadvantaged by these aggressive and often improper utilization review activities, but patients as well. In cases where a patient is utilizing their out-of- network benefits, these activities and the resulting delays, harassment and disallowances can result in reduced or no reimbursement for the benefits patients are entitled under the provisions of their insurance policies. This is a significant economic burden that patients in need of psychiatric care and treatment must absorb. Given the increasing prevalence and exacerbation of mental health and substance use disorders throughout the pandemic, New Yorkers should not have to withstand additional financial strain when obtaining care and treatment in connection with non-compliance by insurers and health plans. Legislation to address this issue was introduced by Assemblymember Gunther, A10303, to require insurers and health plans to comply with the provisions, guidelines and conventions of CPT in connection with processing and payment of claims submitted by physicians.

Recommendations

Attorney General investigation or audit to assure that all psychiatric beds closed for COVID-19 expected surges are reopened and holding those in non-compliance accountable

Continued oversight and enforcement of federal and state parity laws

Urging enactment of A10303 or directive from Department of Financial Services to assure that insurers and health plans comply with the provisions, guidelines and conventions of CPT in connection with processing and payment of claims submitted by physicians

Summary

The response to the mental health crisis requires a comprehensive approach. NYSPA strongly supports the return of all inpatient psychiatric beds that were temporarily closed for COVID-19 surge capacity and an investigation or audit by the Attorney General that assures compliance. We thank the Attorney General for conducting this necessary public hearing.

Gary Horwitz / Rochester, New York

Where can you send your patients for treatment of alcohol or drug use disorders? If a family member needed help, where would you send them? If you or a colleague needed help, what resources would be available in our community? Would you be concerned if the only options available were publicly funded programs which are chronically underfunded? Are you aware that the nearest independent inpatient treatment program, Tully Hill which is south of Syracuse, had put a hold on admissions due to staffing issues related to low funding? It is hard to fathom that such questions arise at a time that substance use disorders are at an all- time high with extraordinary death rates compared to historical norms. In contrast to assurances that windfalls from suits against pharmaceutical companies for their part in the opioid epidemic will be available to fund more treatment and assertions by our political leaders that such treatment is a priority, at this time programs are facing critical financial pressures. The problem of financial instability affects not only publicly funded programs, but also those that are not receiving public funds. Some programs rely entirely on health insurance payments. Inadequate funding from insurance is also squeezing programs out of existence. This may be related to structural discrimination against people with mental health and substance use disorders.

It is now fourteen years since The Mental Health Parity and Addiction Act of 2008 (MHPAA) became law. If you talk with anyone who provides care to these patients, you will learn that enforcement of that law has been minimal. Prior to the law it was common to have quantity limits of a maximum of twenty days of inpatient treatment and similar limits for outpatient treatment as well. There were discrepancies in co- pay amounts compared to primary care settings. Such obvious and blatant quantitative discriminatory practices have subsided. Now discrimination is underfunding to the point of unsustainability of the programs.

In 2021 congress furnished the departments in the federal government with new tools to enforce MHPAA in the Consolidated Appropriations Act. Now the insurance industry must provide comparative analyses of their "non-quantitative" treatment limitations. It is the Department of Labor that is involved in enforcement of the private sector. This is to ensure that benefits to employees, including health insurance, is bona fide. If providers cannot be found, it is a bogus benefit. In this year's Report to Congress about the 2008 Parity Act, they note that:

> For far too long, people with MH/SUD conditions and their loved ones have faced stigma, discrimination, and other barriers inside and outside of the health care system. These biases and discriminatory practices can often operate as an impediment to even seeking MH/SUD treatment in the first place. And once individuals attempt to seek care, they often find that treatment for their mental health condition or substance use disorder operates in a separate, and often very disparate, system than treatment for medical and surgical care, even under the same health coverage.

An example of this is right on our doorstep. A major health insurance provider in our region has not increased rates to a non-publicly funded program for nine years. Attempts to renegotiate for more reasonable and sustainable reimbursement has been stonewalled. In effect, this is abdication of responsibility for care of this population. If it continues, the only option will be publicly funded programs which are also currently facing existential financial problems.

Now for some good news. With the current administration there is an increased commitment to enforcement. The New England and Upstate New York Region of the Department of Labor (617-565-9600) is interested in examining specific cases of such discriminatory practices. Now is the time of greatest need for equity and parity and now is the time for enforcement. Let's end stigma and structural discrimination. Send them cases and let our representatives know your concerns. How do you want your children and grandchildren treated?

Tony Carino / New York, New York

My name is Dr. Tony Carino. I am the Director of Psychiatry at Janian Medical Care and CUCS. For the past14 years, I have provided care to people experiencing homelessness in NYC. I personally care for people who experience homelessness in the Bronx through a homeless outreach team and an Assertive Community Treatment ("ACT") Team and my fellow psychiatrists work to provide care in the city's care gaps and at over 64programs that serve New Yorkers with lived experience of homelessness.

I'm speaking today because I care deeply about our patients, and I've seen them suffer because of barriers to humane and necessary psychiatric care. People with mental health conditions respond to treatment and support when they have access. I will tell you about two cases that illustrate barriers to care and recommend specific interventions to improve access to care.

One of my patients fell in the community and was admitted to a Bronx hospital. The ACT Team discovered he was admitted by calling local hospitals when he was not in contact with us. He had been admitted to the medical floor and was also seen by a consulting psychiatrist working in the hospital. In the community, he had been taking a psychiatric medication called clozapine. Clozapine is a life-saving medication that treats symptoms when other medications fail, it decreases suicide risk and it reduces mortality. The ACT Team and I called the hospital medicine team and consulting hospital psychiatrist. We requested our patient be continued on clozapine while in the hospital so he could continue this life saving treatment and avoid dangerous rebound symptoms. The medicine team and consulting psychiatrist agreed to continue clozapine but failed to do so. The director of our ACT Team visited the hospital and handed the out patient pills to hospital staff and requested they restart the medications again. The hospital failed to restart the medication despite agreeing it was indicated. After being off the medication for 5 days, the patient had worsening of voices and symptoms. Clozapine requires close and careful retitration if abruptly stopped. However, the consulting psychiatrist refused to restart the medication or refer the patient for inpatient psychiatric care at the hospital. He stated that the patient was "not suicidal or homicidal" and therefore should not be psychiatrically admitted, and his hospital stay with medicine was over. Our patient was discharged by the hospital while experiencing dangerous and disturbing voices. The ACT Team rapidly evaluated him in the community and referred him to another hospital where he received necessary hospital care for this new psychiatric emergency.

Another patient experienced a psychiatric emergency, and the ACT Team referred him to a hospital a few blocks away from his and his mother's apartments. We spoke with the psychiatrists in the ER who agreed he required admission. The ER staff reported "there are no beds in the city". The patient spent many hours in the ER and then was transported miles outside of the city to a Long Island Hospital. The ACT Team and I called the hospital inpatient psychiatric practitioner multiple times to provide medication and clinical information. The inpatient psychiatric practitioner from the hospital called back only after we called the director of psychiatry of the hospital. The inpatient psychiatric practitioner was not familiar with NYC based services and agreed to restart the medications that previously were effective for the patient after multiple calls and advocacy by the ACT team and family. His mother was crying and asked the ACT Team why her son was sent so far away where she could not visit him and why the hospital needed so much convincing to treat her son.

The following interventions are needed:

1. Emergency Room and Hospital staff should obtain clinical information from treating outpatient psychiatrists when making decisions about psychiatric or medical admission, treatment planning and discharges. There is an accessible database known as PSYCKES that hospitals can use to identify outpatient treatment teams that are 24/7 accessible.

2. City Hospitals must have both adequate and appropriate psychiatric bed capacity to ensure that patients have access to life saving treatment within the city. The type of psychiatric beds should fit the needs created by psychiatric conditions. Extended Care Units (ECUs) in NYC provide hospital care for longer than the 4-12 days typical of psychiatric inpatient stays. Many people with complex needs such as co-occurring physical health conditions, substance use disorders, and/or homelessness require more than a few days of hospital care. There are only two

ECUs in the city at this time and there should be more.

3. The City should offer accessible crisis support services. Although people may require hospital care, mental health symptoms often worsen in advance of an emergency requiring hospitalization. Patients experiencing mental health crises can often avoid a hospital, incarceration or homelessness if they have access to crisis support services. There are two Support and Connection Centers ("SCC") in NYC; however, community psychiatrists and treatment teams are currently NOT able to directly refer patients to those centers. More SCCs should be developed, and community psychiatrists and treatment teams should be able to directly refer patients to SCCs. Current mental health respite beds known as Parachute beds should be enhanced so they can provide medications and the intake should be streamlined so there is timely access for people in crisis.

4. The State and City should collaborate on another shared supportive housing agreement. Supportive housing is part of the solution to combat homelessness for those with mental health conditions and/or substance use disorders and to increase access to care. Historically, when the state and city collaborate to increase supportive housing, homelessness has decreased through NY/NYI, NY/NYII NY/NY III housing agreements. By embedding psychiatrists in supportive housing sites, barriers to psychiatric care are removed. Another collaboration between New York State and New York Cityto increase the capacity for supportive housing would build community supports and provide access to humane care in the community.

5. The City and State should continue to increase the number of Intensive Mobile Treatment Teams and Assertive Community Treatment Teams so those with high mental health needs at risk of homelessness can receive accessible, community-based psychiatric care.

Alison Burke / New York, New York

Introduction

My name is Alison Burke, Vice President at the Greater New York Hospital Association (GNYHA). GNYHA proudly represents all hospitals in New York City, both not-for-profit and public, as well as hospitals throughout New York State and in New Jersey, Connecticut, and Rhode Island. I work on behavioral health issues at GNYHA, an area whose importance has been highlighted by the COVID-19 pandemic. Thank you for the opportunity to testify today about the state of behavioral health care services in New York State.

As the largest providers of behavioral health services across the State, hospitals and their behavioral health workers have found the past two years particularly challenging. Regardless, New York hospitals are committed to maintaining sufficient inpatient and outpatient psychiatric services. GNYHA believes investing in behavioral health is the single best way we can improve the delivery of care to patients in need.

New York's Current Health Care Staffing Crisis

There is a major staffing crisis among health care workers, including in the behavioral health care space. Although it predates the pandemic for most safety net organizations, the COVID-19 public health emergency significantly worsened the staffing crisis New York's hospitals face. Staffing flexibilities, including the authorization for out-of-state licensed staff to practice in New York, have been a key tool in helping New York's hospitals and other health care organizations meet multipleCOVID-19 waves since March 2020. On September 28, 2021, Governor Kathy Hochul issued a declaration of disaster emergency specifically for health care staffing (separate and apart from the COVID-19 declaration) and has extended it numerous times in recognition that the pandemic has worsened the staffing crisis. The Governor's Executive Order provides hospitals and nursing homes with the necessary flexibility to maintain safe, high-quality patient care despite the statewide health care staffing challenges.

This year's State budget includes a package of GNYHA-supported health workforce policies that address this crisis. These proposals include funding for hospitals and other health care employers to provide bonuses of up to $3,000 to frontline, hands-on health and mental health workers structured to be paid out over time for the express purpose of retaining existing staff members. The budget also includes investments in loan repayment and clinical education support that will attract more people to this rewarding field. New York State has also proposed a five-year long, $13.5 billion request for the Federal government to invest in New York's health care delivery system through a Medicaid "waiver," much of which will be used to further develop and retain the health care workforce.

New Investments in Behavioral Health Care

New York's hospitals and health care workers work tirelessly to save lives and improve the physical and mental health of New Yorkers, a task that the COVID-19 pandemic made more important and difficult. Hospitals incurred greatly increased costs and reduced revenues as New Yorkers deferred necessary non-COVID-19 care. The pandemic also produced a mental health crisis with which we continue to grapple, but without adequate resources. Behavioral health services suffer from woefully inadequate Medicaid reimbursement. In 2020, Medicaid reimbursed only 54%of the cost of inpatient psychiatric care services. Commercially insured patients only represent about 25% of total revenue for these services, meaning public programs such as Medicaid are critical to ensuring that they are available for all patients. This year's State budget was a major opportunity for the State to invest in behavioral health services, given the State's mental health and substance abuse crises. GNYHA advocated for and supported many of the budget's new investments and provisions.

Hospitals provide robust behavioral health services to the Medicaid population and are the providers most likely to treat individuals with serious mental illness, but Medicaid rates for mental health services are extremely low. Without more funding, it will be extremely difficult for hospitals to maintain their current capacity, let alone increase it. For instance, one New York City-based hospital system reports that Medicaid only pays 55% of the costs for inpatient bipolar disorders and only 52% for inpatient schizophrenia cases.

To begin to address this issue, as part of the Human Services cost-of-living adjustment provision, this year's State budget provides a one-year, 5.4% increase for outpatient behavioral health services, including those provided by hospitals. It also provides several million dollars for loan forgiveness to recruit psychiatrists and psychiatric nurse practitioners and $1.5 billion for supportive housing as part of the budget's five-year housing plan. The budget also mandates telehealth reimbursement parity for Medicaid and commercial plans, with limitations on the reimbursement of facility fees in certain circumstances. Behavioral health-related telehealth greatly expanded during the pandemic, enabling continuity of care and providing much-needed access. Finally, the State budget reinvests $111 million from Medicaid managed care recoupments into behavioral health services and includes $400 million ($200 million State share) to enhance Office of Addiction Services and Supports programs and services to combat the opioid epidemic.

In addition to the above budget investments, the Governor announced on February 18 that her Administration would invest $49 million in various mental health initiatives, including $27.5 million to enhance access to inpatient psychiatric services by increasing Medicaid fee-for-service rates by 20%.

We are hopeful that these new investments in behavioral health will strengthen both inpatient and outpatient services, address the payment-to-cost gap, and support the recruitment and retention of highly qualified staff. GNYHA strongly supported the Governor's mental health initiatives and the behavioral health investments in the State budget. We will continue to advocate for Albany to build on this critical investment in behavioral health services during future budget cycles.

From Institutional to Community-Based Care

While the popular focus is often on inpatient services—delivered within a hospital's four walls to patients requiring high levels of care—New York's public and voluntary hospitals have in recent years shifted toward providing more outpatient services, particularly through the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP, a State-Federal initiative that lasted from 2015 to 2020, successfully reduced avoidable hospitalizations, including psychiatric hospitalizations.

New York's hospitals and health systems have made enormous investments in ambulatory psychiatric care. It is generally preferable, when possible, for psychiatric patients to access treatment and recovery services while remaining in the community, whether at home with the support of family members or in another non-institutional setting. There will always be a need for robust hospital inpatient behavioral health services—sometimes they are the only option—but care delivery is changing, and ambulatory services are a significant component of that future. Given the limited resources, it makes sense to provide other important community services, including ambulatory psychiatric care, that better reflect the latest clinical advances and community needs. Any review of behavioral health service utilization in New York State must examine this trend and include ambulatory care data alongside inpatient data to get a complete picture of the services available and utilized by New Yorkers.

Conclusion

Despite the challenges presented by the ongoing staffing shortage and the COVID-19 pandemic, hospitals continue to provide essential behavioral health services and are committed to maintaining robust behavioral health capacity. We are hopeful that the State's major new investments will help ease the health care staffing shortage and rebuild New York's health care workforce. GNYHA looks forward to working with you to strengthen our health care system and the behavioral health services it provides.

Stephanie Martin / Centereach, New York

As a mom with a 16-year-old son dealing with mental illness my concern is there's low accessibility to mental healthcare and the options that are available are low quality. Down the line this leads to life altering complications like homelessness, incarceration, or just struggling in general. As a society we need to implement quality services to prevent such things from happening. College/higher education does not have any services in place to help our kids strive to be the best they can be in our society. My question is if prison systems and hospitals have tools in place to help people who deal with mental illnesses why can't we implement such services to our school system. Given the options available I fear for my child's adult life.

Victoria Pham / New York, New York

I am the Chief Medical Officer at the Institute for Community Living (ICL), a New York City based nonprofit that works with about 14,000 individuals a year, including many with very serious mental health challenges and substance use disorders. I'm also a board-certified adult and child psychiatrist and have worked in many levels of care, including in inpatient psychiatric units. The issues we are here to discuss today are one I have seen and witnessed over the years.

If you spend the day at ICL – and I invite you to visit, we're in your backyard in Brooklyn – you'll clearly see the impacts of the inadequate mental health system we face when working to support our clients, specifically those with the most serious problems. When our clients need a greater level of care than we can provide, we find capacity shortfalls in programs and a lack of inpatient beds. We also come up against inadequate technology and fragmented communication and coordination with other systems.

As a result, the people who most need care are least likely to get what they need. They suffer and so do all the members of our communities. Fixing the mental health systems is a public health imperative as we are all impacted by its shortcomings.

I'm very grateful to the state for its commitment to addressing the mental health system problems. But clearly, much more is needed to ground the skyrocketing mental health crisis. I'll outline a few key areas where I think focus is needed:

Inpatient psychiatric beds have been decreasing over the years while demand has been increasing. This has led to prolonged wait times at emergency departments. It's not unusual for us to see people wait between two and seven days for a bed. While they wait, they just stay on a gurney, often in a hallway. It's wrong. This impacts quality of care and prolongs and complicates treatment.

But more inpatient psychiatric beds are not enough. That's because once individuals are discharged, the system lacks the coordination to ensure an appropriate continuity of services. That's why you see people cycle in and out of emergency rooms.

We need real time coordination between hospital systems, outpatient services, criminal justice systems, and substance use treatment programs, so that we can create and implement collaborative treatment plans that work.

Right now, people too often get discharged with fragmented medical and psychiatric follow-up plans. At times, there is no continuity. Sometimes, a patient needs to wait a month or more after discharge to be seen in the community. We also deliver a lot of redundant services because of a lack of coordination. Duplicative blood work, imagining, and more, which needlessly drives up costs and reduces quality of care by subjecting people to needless procedures.

It's worth noting that the state developed PSYCKES – statewide web-based HIPAA-compliant platform to consolidate psychiatric services. It's a good start but we need to expand the system. For example, in Ottawa & Calhoun counties of Michigan, they have real time coordination among social services, healthcare systems, substance use/mental health treatment and criminal justice system to reduce recidivism while effectively helping clients.

Hospital beds and better coordination will only solve part of our problem. The fact is, not everyone needs the level or kind of care a hospital provides. But other intensive intervention options are limited.

We need to see increased funding for levels of care that are closer to inpatient, such as Intensive Crisis Stabilization Centers, CPEPs, Residential Respites, and Supportive Crisis Stabilization Centers. Giving providers options that are appropriate won't stress the hospital system and will result in more appropriate care setting and services. With serious mental health challenges, there is not a one-size-fits-all solution—providers like us at ICL need more options with availability.

We also need to see increased flexibility in the system that enables providers to utilize telehealth in different levels of care, including inpatient. Telehealth, moving forward, must include the telephone.

After all, not everyone has a smartphone or access to telehealth portal. Thus, not having telephone option in telehealth services exclude those who do not have economic resources and/or experience a disability. Other patients have broadband connection issues that present additional barriers. During the height of the pandemic, I found myself in sessions with patients I couldn't see or had problems communicating with because of WiFi problems and whose connection went in and out. Patients with developmental disabilities also have challenges using televisual platform. We need telehealth and telephonic flexibility at all levels. We hope to see that flexibility in the system moving forward.

To recap, more inpatient psychiatric beds, better communication and coordination, expanding intensive service options, and flexibility in telehealth, we believe will go a long way to addressing our mental health crisis. So will targeting those individuals with high risks factors, co-occurring medical/ mental health/ substance use conditions, chronic and serious mental illness, and high utilizers of services. Patients who had hospital admission within last 30 days or at least four emergency department visits for the same condition within last year – that is an example of targeted segment that we should look into and focus on. Focusing on those individuals and ensuring better outcomes for them is key.

Of course, in the backdrop of all of this are huge workforce issues. As you well know, the sector—and specifically nonprofits contracted by government to support individuals with the greatest challenges in getting better—have significant challenges in attracting and retaining top talent. Our pay scales are woefully inadequate, and when you couple that with the environments where we provide our services—like shelters, for example—and the severity of supports our clients need, you aren't surprised by the outcomes.

We face sky-high turnover and vacancy rates. It's unsustainable and if nothing is done, it will lead to the further deterioration of services for people with serious mental health challenges.

Just listen to these numbers and you will see:

> The turnover rate in our homeless shelters is 58%.
>
> The turnover rate in our clinics is 44%.
>
> And our ACT and IMT teams—which provide comprehensive services to the most hard to reach and hard to treat individuals—see a 31% turnover rate.
>
> And we have huge vacancy rate, including 21% in our shelters, 20% in supported housing, and 34 % in our residential programs.

We need to fix this. We need higher wages. We need pay parity. We need COLAs that keep up with rising costs.

I do want to acknowledge the 5.4% COLA from the state, but we need greater investment.

There have been historical mental health provider shortages, predating the pandemic. Two thirds of primary care providers have trouble finding mental health providers to refer patients to. The reason for this is low pay, high burnout and lack of instant gratification. Success with patients happens over time. We need innovate solutions and investment from the federal government to address these substantial issues.

I know there are talented people out there who want to do this important work. They just need to be able to afford it.

Evelyn Graham-Nyassi / New York, New York

I would like to thank Attorney General Letitia James for allowing me the opportunity to testify at this hearing.

As a peer with lived experience, which means one who has recovered and has successfully navigated the mental health system. I can testify that one of the problems with New York City's mental health system can be traced back to the many forced hospitalizations that occur as a result of a police response to those who are experiencing a mental health crisis.

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 my sofa quietly, when someone knocked on my door it was the police. A family member had called 911 and told the operator that I had a knife! Eight-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 ambulance. I chose the ambulance. Another police officer said that he would ride with me. They dropped me off at Bellevue Hospital, which was the 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 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 learned that I was stuck until Tuesday! When Tuesday finally came around, I was taken upstairs to the ward and wasn't released until 2 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 a peer with lived experience, like the one CCIT NYC proposes, to prevent me from being hospitalized in the first place.

Correct Crisis Intervention Today, CCIT-NYC, is an organization consisting of 80+ Mental Health Advocacy organizations. Which initially favored all for the NYPD police being 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's PROPOSAL

CCIT-NYC proposed mental health crisis response system is modeled after the CAHOOTS program, in Oregon with a 35+year successful track record. CCIT-NYC is advocating for NYC to contract with community-based organizations to establish mental health crisis response teams that consists of one crisis counselor, who is a peer who has received extensive training in crisis de-escalation and one emergency medical technician, who is not an employee of the NYC Bureau of Emergency Medical Services (EMS).

The core characteristics of the CCIT-NYC proposal are:

1. non- police, non-coercive teams that are the default response to all mental health and substance use crises;
2. community-based members;
3. operates 24/7
4. Response time comparable to a response time for other emergency matters;
5. Peer-led leadership with peers hired from affected communities on every crisis response team and in program leadership and on the oversight board;
6. Follow-up care-connecting recipients to voluntary services that includes housing and social support systems, such as crisis respites, and diversion centers;
7. Transparency
8. evaluations to collect and analyze data regarding long-term outcomes, including housing availability, completion of treatment programs and avoidance of future hospitalizations;
8. partnerships with community organizations and mental health advocates already working in the space and
9. uses 988, which will be activated in New York as of July 16, 2022, as the call-in 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 crises. 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 deaths and abusive treatment of innocent people experiencing a mental health crisis.

Nicole McVinua / New York, New York

I am the Director of Policy at Urban Pathways. Thank you for the opportunity to testify at today's hearing examining access to mental health care for people with serious mental illness in New York state.

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 a unique combination of street outreach, drop-in services, safe havens, extended-stay residences, and permanent supportive housing. Our extended-stay residences are licensed by the State Office of Mental Health (OMH) to serve people with serious and persistent mental illness. Our Permanent Supportive Housing programs also serve people with serious mental illness, with services funded by OMH and the NYCDepartment of Health and Mental Hygiene (DOHMH). In addition, our organization offers a wide range of additional programming to meet the needs of our clients, including our Total Wellness Program, Upwards Employment Program, and Consumer Advocacy Program. Additionally, we offer two programs that specifically serve New Yorkers exiting incarceration. Urban Pathways serves over 3,900 New Yorkers in need annually across four boroughs.

Urban Pathways has seen increased challenges in getting our clients access to the mental health care they need, in both outpatient and emergency settings. These challenges has significantly increased since the onset of the COVID-19 pandemic. This is deeply concerning, especially considering the toll that the isolation caused by the pandemic has taken on all New Yorkers, and the increased mental health concerns our clients have faced. This is evident in the significant rise in substance use that we have seen amongst our clients and residents since the start of COVID-19. This rise in substance use is visible in the increase in severity of substance use, an increased number of clients with previous substance use disorders experiencing relapses, and the development of substance use disorders amongst those who had not misused substances prior to the pandemic. The increased use of substances as a coping mechanism is demonstrative of the toll taken on those living with mental illness since March 2020.

As the need for mental healthcare has increased, 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 waitlists to be seen and limited appointment times when they become available. This leaves our clients in need of services waiting for weeks and even months to be seen. Because of their limited capacity, most psychiatrists accepting Medicaid require individuals to come to two to three intake appointments before they can become a patient. This can be an arduous and frustrating process for a person living with a serious mental illness that is often difficult for them to complete, especially considering they are typically not currently receiving the psychiatric care and medication they need. When an appointment is missed, this person must start the intake process over again, leaving them for additional weeks or months without care and multiple appointments they must get to. 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. New York desperately needs more psychiatrists who are accessible to low-income people and people with Medicaid as their primary insurance.

When care is accessed, it is notable that it is often a lower quality of care than would be acceptable for an individual receiving treatment with private insurance. This speaks to the overwhelm of those providing access to care for low-income individuals due to a lack of providers, as well as the stigmas faced by low-income individuals living with serious mental illnesses. There must be access to the highest levels of care if we would like to truly address the mental health needs of all New Yorkers.

When a person is experiencing a mental health crisis, there are significant barriers to accessing emergency care, from the response to emergency department services, to discharge planning. The typical response to a mental health crisis when 911 is called is to send police. While there have been and continue to be efforts under way to remove police from mental health response, access to alternatives are still not as widespread as is needed and none are available 24/7. For example, New York City's Mobile Crisis Teams are a non-police response team composed of behavioral health professionals, such as social workers and peer specialists. However, they are only available between 8am –8pmand are not always available to respond immediately. Their website indicates a typical response time is within two hours, but our programs' experience is

that it may be up to 24 hours before they respond. The B-HEARD program that is being piloted in some neighborhoods and has received additional funds to be expanded in the city's FY2023 budget is another example of a non-police response that is needed but falling short.The B-HEARD teams include a mental health professional and two EMTs. While positive results are reported when they respond, from June –November of 2021, only 22% of 911 mental health crisis calls in the areas where the program exists were routed to B-HEARD teams by dispatch, and due to the lack of an available team, did not respond to 18% of the calls that were routed to them. Similar to Mobile Crisis Teams, B-HEARD teams are only available for 16 hours a day.

This leaves NYPD responding to the vast majority of mental health crisis calls across New York City, which according to a 2019 report from Public Advocate Williams doubled from 2009-2018 to nearly 180,000 calls annually. When police respond, even if the person is being transported to the hospital, they are still often placed in handcuffs. This can be a traumatic event for the person in need of assistance and criminalizes them for having a mental health emergency. This is not how people in crisis should be treated. Police and EMTs are not typically trained to recognize a mental health emergency, and the presence of police may escalate a situation unnecessarily. New Yorkneeds24-hournon-police response options, as well as the presence of Peer Specialists on these teams who can communicate effectively with those in crisis as persons with lived experience.

When someone is having a mental health crisis that requires immediate care and are taken to the emergency room, or they walk into the emergency room on their own, they are typically sent back to their supportive housing residence or temporary residence (such as a Safe Haven or Drop-in Center) without communication from the hospital as to the result of their visit. Often, they are not held for observation and are sent back the same day if they are not actively demonstrating symptoms of psychosis while in the ED. This has become worse since the onset of the pandemic due to the shortage of beds and prioritization of COVID patients. When they arrive back at their residence, there is sometimes no communication made or paperwork provided from the hospital for the staff at the program as to the client's discharge plan. This leaves the staff in the dark as to how best to support this individual. While HIPAA regulations must be followed, the hospital staff does not always offer our client a release that if signed would allow better coordination of their care between the program staff at their place of residence and the hospital team. Even when a case conference is requested by program staff, this request is not always responded to. The lack of coordination in discharge planning can create a cycling between the hospital and their residence. There must be a better system of communication put into place to ensure continuity of care, while maintaining the right to privacy.

There must also be stop gap measures considered for individuals who are currently homeless, and cycling between the hospital and the street, or the hospital and the shelter system. The instability of homelessness can exacerbate a person's mental illness. If the process for accessing supportive housing could be expedited for those with repeated hospitalizations, this would help them gain stable housing more quickly and allow for greater stability. It is also notable that the increase in wait times to be receive a psychiatric evaluation is impeding housing applications for those who are currently homeless. Clients who are residing in our drop-in center, stabilization beds, and safe havens are waiting weeks or even months to receive the psychiatric evaluation needed to complete the CAPS survey to determine if they qualify for supportive housing. This holds up their ability to even begin the application process for supportive housing or housing subsidies, prolonging their homelessness. Expeditious access to psychiatric evaluations is needed for New Yorkers experiencing homelessness.

In conclusion, people living with a serious mental illness need increased access to high quality psychiatric care when using Medicaid, non-police responses to mental health crises that are always available, increased access to emergency care, and increased communication between temporary shelter and supportive housing staff when residents are discharged from emergency care.

Jed Wolkenbriet / New York, New York

I am Counsel to the New York State Conference of Local Mental Hygiene Directors (the Conference).

The Conference was created pursuant to section 41.10 of the Mental Hygiene Law and its members are the Directors of Community Services (DCS) for the city of New York and each of the other counties in the state. DCSs serve as the CEO of the Local Governmental Unit (LGU) defined in the statute as the portion of local government responsible for mental hygiene policy and responsible under statute for the planning, development, implementation, and oversight of services to adults and children in their counties affected by mental illness, substance use disorder, and intellectual/developmental disabilities. As such, DCSs have linkages to all of the various health and social service systems in their jurisdictions and have a unique view of the needs of and problems facing the people they serve. Most often, these needs are not limited to a single service but rather are complex and extend beyond the scope of behavioral health care and into other distinct areas, such as housing, public benefits, the criminal justice system, and the county jail.

It is the community mental hygiene system that must pick up the pieces when others fail to appreciate or do not care about the implications of their actions. The haphazard deinstitutionalization of patients from state mental health facilities without effective discharge planning, the severe federal cutbacks in aid during the early 80's, the closure of state inpatient beds in an apparent desire to save money and without adequate community supports, have increased the pressure both on Article 28 hospitals and local community services to provide for the welfare of individuals suffering from serious mental illness (SMI) who need a more intensive level of care. While we recognize the benefits and importance of treating people with mental health disabilities in least restrictive settings, we also realize that people on the road to recovery may, from time to time, need a period of hospitalization to help them handle some of the challenges they may experience along the way. The closure of both state-operated beds, as well as the reduction in Article 28 beds combined with reductions in local resources caused by insufficient State Aid and depleted workforce, has brought many communities almost to a breaking point.

As we all know, over the last two years, the COVID-19 pandemic has exacerbated the situation and brought to light the breakdown in the State's behavioral health system. Across the State, Article 28 hospitals facing capacity issues and bed shortages coupled with emergency measures required by the pandemic and drastic workforce challenges, are making decisions to temporarily, and in some cases permanently, close inpatient psych units. Most crisis evaluations occur in ED-based crisis units. The demand for these evaluations has increased tremendously during the pandemic. Additionally, mobile crisis services are limited in most counties due to workforce shortages, creating limited access to this service which is a front line in diversion from the inpatient crisis units. The authorization of Comprehensive Psychiatric Emergency Programs (CPEP) in the late 80's was designed to provide a systematic response to psychiatric emergencies, however many of our counties do not have access to these treatment facilities. Ultimately, our jails and prisons are too often becoming the primary source of mental health treatment.

EDs frequently reach capacity, resulting in a need to go on "diversion" status. This results in the need for neighboring hospitals to cover. Those in need of psychiatric crisis evaluations are then transported to hospitals outside of their immediate community. At times, capacity is reduced drastically because there is not the staff to provide the required staffing of psych patients who are in a general ED bed awaiting crisis evaluation.

We all know that psych beds are not money makers but they are a critical component of a proper system of care, and the Department of Health (DOH) and the Office of Mental Health (OMH) must do a better job at regulating hospital administration policies, especially related to their decisions to close these beds. Our state partners must work more closely with the county departments of mental health to determine appropriate planning and treatment needs. It is clear, now more than ever, that a top down policy approach does not adequately allow for the best outcomes. Proper development of care coordination policy should involve strategic local planning and ongoing collaboration with county mental health departments. This increased collaboration will significantly offset the breakdown in the behavioral health care system we are witnessing today.

Additionally, access to high acuity care in adolescent psych inpatient units is becoming increasingly threatened. Many of our counties are facing immense challenges in finding inpatient psych resources for children, resulting in more youth being transported outside of the area for admission. Without proper access, we see this care fall to community crisis first responders (law enforcement and crisis teams) who are not appropriately equipped to treat the seriously decompensating mentally ill.

Recommendations for Consideration

1. If hospitals and/or State PCs are allowed to continue to take beds off-line or temporarily close, any monetary savings must be returned and reinvested back into the community. These investments are critical to our providers who are left at the bottom of the safety net caring for these clients while they are unable to access inpatient services they need;

2. DOH should have a daily reporting system of hospital systems which can be accessed by the counties that shows bed capacity, including any beds taken off-line. Community-based providers are required to do such reporting, and we should expect the same from the State.

3. OMH's PC admission criteria and referral process via the Health Commerce System (HCS) should be reassessed for a smoother system transition from hospital inpatient to State PC. The process currently in place was established several years ago as an OMH pilot across NYS to be reviewed and evaluated to ensure that no bottleneck affects hospital to state PC referral process. The pilot has revealed it is time to update and review that process to avoid delayed access to state PC beds.

Michael Galipeau / Red Hook, New York

I am a social worker and certified peer recovery advocate who has spent the past 3 years working supporting individuals with mental health and substance use disorders here in New York State. I am writing you today to share with you that in my experience mental health treatment access is in a critical state. Having worked in multiple surrounding states, it is my experience that access to mental healthcare in New York State is the most challenging and extreme. These disparities have put many vulnerable people and the community at risk, leaving individuals who have a need for a higher level of care without support or resources to initiate and sustain recovery.

As an example: I was working with an individual who was referred to my drop-in center by our County Executive's office. His father was an incredible advocate for this individual and followed every possible lead he could find to get help for his son. When I first encountered the case, he had just been admitted to the local hospital. He had experienced severe mental health decompensation and was experiencing psychosis. He thought that he had been using drugs, however nobody had thought to drug test him to check his urine that he was in fact using drugs. He had walked into a stranger's home, sat down on the couch, thinking somehow that this was somewhere he was supposed to be.

Upon discharge, he was released without any coordination of care and had medication left unattended at the hospital, meanwhile social services had placed him into emergency housing at a local motel that was completely inaccessible to his medication. He had no transportation to get food, and no local resources to access from this location. When he ultimately failed to remain there successfully, he was brought to the shelter by our mental health crisis team. He was discharged shortly after, having been determined to be inappropriate for shelter based on the level of his care needs. After his discharge he was thrown into a series of serial hospitalizations because appropriate care was not available. Waiting lists to get into a higher level of care for mental health was over a year. This young man was not appropriate for shelter care and was thrown into very dangerous circumstances where it became likely this young man would lose his life. His father was terrified that this would happen, and contacted everyone possible, which is what landed him at my desk.

The reality is that our mental healthcare system is deplorably underfunded, and lacks needed capacity. One of the ways we can resolve this is to immediately pass the Treatment Not Jail Act. Investing our limited resources in community-based services and not incarceration is critical at this juncture in our history. Many individuals with mental and physical disabilities

are characterized by serial incarcerations and chronic homelessness. We must change our course and invest in our communities. Incarceration is traumatizing and further harms vulnerable people. We have a responsibility to address the injustices left behind by the closure of the state hospital system. Our criminal justice system has become the de facto state hospital, however this is costly and ineffective. We must change our approach and invest in communities now.

Christine Scheinman / Dix Hills, New York

My testimony is about my daughter who last year needed to be admitted to a pediatric psych in patient unit. She was 11 years old last March 2021 when our nightmare started. We were seeing a psychiatrist who advised us to bring her to Stoneybrook CPEP which has a pediatric section, but parents are not allowed in. She had thoughts and a plan to kill herself. She stayed overnight in this pediatric psych ER, and I was the one who found the inpatient bed that was all the way up in White Plains. Being in healthcare myself I knew where to call around. The social worker at Stoneybrook can only call local hospitals. After her 10 Day stay at NYP in White plains she was discharged. A week later she admitted she was not better, and I was directed once again to take her to Stony Brook CPEP. This is where the damage was done bc there were NO inpatient beds available for 6 days!!! She was kept in CPEP, and my husband and I could only speak to her on the phone. As I mentioned before no visitors were allowed. She witnessed another child have a grand mal seizure and now suffers from PTSD from having this experience. She eventually got a bed at South Oaks on Long Island and stayed almost 3 weeks. I was able to ride in the ambulance with her from Stoneybrook to south oaks and when I saw her, I was shocked and heartbroken. She was a different child. She was withdrawn and unkept, her hair not even brushed for days. It's over a year later and she still has trouble going to sleep at night bc of her time being stuck at Stoneybrook CPEP. The guilt I carry with me as a parent is almost too much to handle knowing that I couldn't get her out of there sooner as I desperately called all the pediatric inpatient psych units. She met criteria for inpatient admission, and I was advised not to take her home even though if it had been one more day, I was going to get her out of there.

Children are in crisis and there are not enough providers or beds to treat when inpatient care is needed.

In regard to access to outpatient care that is another major issue. My daughter is lucky in that we are able to pay out of pocket for her psychiatrist and psychologist and then submit to our health insurance for out of network benefits. Hardly any mental health providers take insurance. And I understand why because the reimbursement rates are awful. This is the reason why there are not enough inpatient beds either. Because the hospitals do not make money on these beds. The reimbursement rates are terrible. It is on the legislators of NY state to force insurance companies to have fair and appropriate payments for mental health providers. The time it takes for me to get the bills from the providers and submit to insurance can be a full time job!

It doesn't make sense that I can take my daughter to a doctor that specializes in adolescent medicine who gets $600 covered by insurance but I can't take her to a psychiatrist who charges $250. Her therapist charges $150 which is completely appropriate. How can insurance not cover these costs?? The urgent care center gets paid $250 when I bring my child in to get a strep test or Flu test. And we are there for maybe 20min.

My daughter is doing better thanks to her providers, but we still have long way to go. She suffers from anxiety, depression, adjustment disorder, school anxiety, and autoimmune encephalopathy.

Please as a parent I am begging you to do something to make sure no parent has to go through what we did in seeing our daughter suffer because there were no beds available.

Cal Hedigan / New York, New York

Thank you to Attorney General James for convening this hearing and prioritizing mental health care accessibility in New York. As the CEO of Community Access, I lead an organization that is one of the most progressive and rights-based supportive housing and mental health agencies in New York City. Our staff consists of more than 350 people who work daily to support thousands of individuals living with mental health concerns in accessing services and living self-determined lives in the community.

We are also one of the leading providers of supportive housing in New York City, and we are the originators of an integrated housing model, which has become a best practice nationally: affordable and supportive housing where families reside alongside people living with mental health concerns. We support thousands of New Yorkers living with mental health concerns through supportive housing, mobile treatment teams, job training, supported education, advocacy, crisis respite, and other healing-focused services. Community Access is also proud to be a founding member of the Correct Crisis Intervention Today in NYC Coalition (CCITNYC), which is committed to transforming New York City's mental health crisis response.

I must begin my testimony by discussing the need to shift the focus away from short-term inpatient psychiatric services when addressing our state's mental health crisis. Accessible mental health care should be a top priority for New York, but relying on inpatient institutional approaches results in outcomes that do far more harm than good. For too long, the default destination for New Yorkers in crisis has been the emergency department, inpatient hospitalization or incarceration. While there is the need for a small availability of inpatient services, the future of our mental health care system must be rooted in approaches that are rights-based, peer-informed, culturally competent, trauma-informed, and truly person-centered. These strategies promote recovery and respect the human rights and dignity of people living with mental health concerns.

We need a spectrum of services, provided by peer-informed, community-based organizations, that offer accessible preventive services, timely trauma-informed crisis response, and post-crisis connection to a truly person-centered and rights-based public mental health system. By the time someone experiences a mental health crisis, the system has already failed them. Instead, we must ask people what they need, or needed, to avoid the crisis situation. People are experts in their own lives, and our mental health system must respond to that basic truth, taking people's expressed needs as our guide. Then we can build the community supports that will prevent crises in the first place. We need a greater investment in these approaches, not inpatient psychiatric beds.

As a mental health service provider, I have seen firsthand how transformative the right approach can be for people who have not been well served by more traditional models. Community Access' Crisis Respite Center is a prime example. The center offers an alternative to hospitalization for adults experiencing a mental health crisis. Guests at our crisis respite center find warmth, empathy, and a welcoming environment. The center is almost exclusively staffed with peers, people with lived mental health experience. Individuals can come and go from the respite as they please, and have access to recovery-oriented services, including 24/7 peer support. Community Access' crisis respite center has been serving New Yorkers experiencing psychiatric crises since 2013 – in a voluntary, non-coercive community-based setting. It is a model for non-institutional crisis response. We look forward to building on this peer informed approach when we open our first intensive residential crisis program in 2023. Our program, slated to open on the Lower East Side next year, will be another opportunity to demonstrate the efficacy of non-coercive, non-institutional approaches to meeting the needs of people experiencing psychiatric crises.

A just future for all New Yorkers cannot rely on coercive and discriminatory models of intervention. We insist that any services and treatments New York State employs to support people living with mental health concerns be devoid of any coercive measures. Time and time again, tragic cases in which people have fallen through the cracks illuminate the failures in our public mental health system but involuntary, coercive interventions are not the answer.

Community Access opposes the state's recent expansion of Assisted Outpatient Treatment (AOT) colloquially known as Kendra's Law. In addition to the problematic involuntary aspects of AOT, the policy has been deployed in discriminatory ways – since its inception, 77% of AOT orders have involved BIPOC people in New York City This is another compelling reason that it should not be relied on. Instead, we need more investment in proven strategies that promote recovery and respect the human rights and dignity of people living with mental health concerns.

And finally, Community Access supports New York's efforts to fund the 988 crisis hotline infrastructure as an alternative to 911 While we understand it will take some time for the education and public awareness work to take hold, an alternative to 911 for crises will save lives. This new system must move us further away from having police officers respond to mental health crisis calls—a policy priority Community Access has been championing for decades, both on our own and as founding members of CCIT-NYC.

Thank you for the opportunity to submit testimony. I look forward to working with the Attorney General James, as well as our partners at the NYS Office of Mental Health, to advance community-based service options and ensure providers statewide have the resources they need to offer the supports our communities rely on.

Glenn Liebman / Albany, New York

I am the CEO of the Mental Health Association in New York State (MHANYS). Our organization is comprised of 26 affiliates in 52 counties throughout New York State. Most of our members provide community based mental health services such as housing, care management, clinic programs, peer services, family services, prison and jail diversion, school based mental health services, suicide prevention programs, veterans' mental health and much more. Our work is mission driven and the fabric that brings us together is our belief that in fighting stigma and discrimination and focusing on individualized services that people can recover and live successful lives in the community. Our organization is very involved with advocacy both at the State and local level. We were the leaders in helping to make New York the first State in that nation to mandate the teaching of mental health instruction in school. We have also been engaged with many other anti-stigma efforts. We are involved with major mental health budget issues, some of which we will address in this testimony, including priorities around funding the workforce, housing, criminal justice reform, veterans' mental health, crisis services, issue of Diversity, Equity and Inclusion (DEI) and linkages between mental health and substance use. In short, our advocacy is focused across the life span---a theme that will be continued to be addressed throughout the testimony COVID has completely changed the narrative around mental health. As we have often said, there are two pandemics. The first one is the one we have seen every day for the last two plus years of lives we have lost, the unbearable pain of their loved ones and the incredible heroic workforce that was doing everything in their power to help save lives.The second one has been more hidden—the mental health pandemic. The grief and isolation across all sectors has resulted in increases in rates of depression and anxiety and around bi-polar disorder and schizophrenia. While the numbers for people impacted with mental health issues is traditional 1-in-5 adults and children, those numbers have more than doubled since the pandemic. Sadly, the number has been even higher in communities of color. An already massively underfunded mental health system is now facing an unprecedented increase through COVID.

An unprecedented need calls for extraordinary efforts and expansion. The Governor and the Legislature have responded to this need with more mental health funding in the budget then we have had in many years. Priorities around workforce, community mental health services, crisis services and housing have been addressed with a combined influx of State and Federal dollars. We are appreciative of these efforts and we thank the Governor and the Legislature for their leadership but the reality is that we are still in a mental health crisis in New York State. Listed below are several recommendations from MHANYS on how we can address this crisis and provide supports and services we need to help respond to the crisis.

Workforce

The strain on the mental health workforce throughout COVID starkly demonstrated both heroism and unmet need. The mental health workforce like the health workforce responded every day during the bleakest times of COVID. Our workforce was front facing every day in residential programs, in hospitals, in correctional facilities and other sectors. Their heroism and courage was unprecedented and we all owe them a great deal of gratitude for working with the countless number of people with mental health issues that were facing COVID challenges. Yet through all these great deeds, this workforce was being compensated less than people working in the service sector. Sadly, that is still too often the case. A top priority must be the ability to raise the wages of our workforce. People take jobs in our sector because they are mission driven and believe in our cause, but mission driven doesn't pay the rent. We need continued support. This year's Executive Budget ended a fourteen year struggle to fight for a full COLA for the mental health and human service workforce based on the Consumer Price Index (CPI).Governor Hochul's budget included a 5.4% COLA for our sector. This addition along with the$3000 one-time direct care stipend are both major positive steps but as we all know, more needs to be done.

Recommendations

» We urge Attorney General James to continue your support for the workforce in working closely with the Governor and the Legislature in supporting a full human service COLA based on the CPI in the 2023-24 budget. It is not too early to advocate for this change and we strongly urge her continued support.

» Work with our mental health and human service sector around best practices in our field to retain and recruit quality staff. Career ladders, tuition reimbursements, elimination of student debt and other mechanisms should all be on the table for our workforce. The strong bully pulpit of Attorney General James will help lead this fight.

» The workforce must represent people that are facing greatest challenges. We have to provide greater effort of recruitment and retention of clinical staffs in communities of color. There is a woeful need for more psychiatrists, psychologists, social workers and mental health counselors that are brown and black. We need your continued support to help raise the visibility of this important issue.

Housing and Other Community Supports

New York is a national leader in housing support for people with mental health issues and there was unprecedented funding to increase the need in this year's budget but sadly, with all that said, it is not enough. Just look at the numbers. There are over 800,000 people in New York's public mental health system. While over 100,000 have community supports (far bigger than other States), that is a small number compared to the need. While many people live independently, there are still many stuck in psychiatric hospitals, in adult care facilities, in correctional facilities, in general hospitals and living with aging families. We have to address those needs and pay our workforce a livable wage. We also have to address the mental health needs across the community sector from child care, to youth services and adult services. We need an influx of funding to help support the provision of mental health services community that will keep people in their communities and not in hospitals or correctional facilities.

Recommendations

» Continue to work with advocates, the Executive and the Legislature to prioritize housing for individuals with mental health issues

» Continue the efforts of the behavioral health advocates in fighting to add $500 million to the 23-24 budget for behavioral health services. We urge the support of Attorney General James.

Criminal Justice Reform

We thank the Attorney General for her leadership in fighting for reform of the criminal justice system. Nowhere is this issue more evident than with individuals with mental health issues. The number of individuals with mental health issues in jail in New York is over ten percent for men and over 20% for women. Almost 3 out of every 5 people in prison have a serious substance use issue. New York's correctional system has served as de-facto psychiatric hospitals over the last two decades. There are several recommendations we put forward to help eliminate the mass incarceration of people with mental health needs.

Recommendations

» Work with the Executive and the Federal Government to insure that there is support in Medicaid for in reach services and supports for incarcerated individuals thirty days before they are released from prison. Those thirty days are crucial to insure that individuals are linked with services and medication immediately upon discharge. If those services are not immediately in place than the likelihood of recidivism increases dramatically. The State's 1115 proposed Waiver proposal clearly lays out the need for those services being in place upon discharge. We urge the support of the Attorney General in advocating for those changes.

» We strongly support the Governor's funding for five hundred additional supportive housing beds to house people who have experienced homelessness. Many individuals that are homeless end up incarcerated for no reason outside of the fact that there is no other housing alternative in place. Providing those beds will be helpful in avoiding incarceration. In addition, those beds will provide stability. We urge support from the Attorney General to advocate for more services for those individuals. It is one thing to house individuals, it is another to provide immediate and necessary mental health services for those in need of those services.

» Medication Assistance Treatment is a best practice in the field of Addiction Disorder. We are doing a dis-service to an entire sector of the three in five individuals in prison for substance use if they do not have immediate access to life-saving medications. This must become available in every correctional setting. Without these lifesaving medication, many individuals with substance use needs immediately go back to their opioid addiction after release.

School Based Mental Services

In 2016, New York became the first State in the nation to pass legislation mandating the instruction of mental health in schools. As part of implementation, a workgroup was created that brought together leaders in education and mental health to help formulate a policy response to the mental health crisis in schools. The Legislature and then the Executive have funded a School Mental Health Resource and Training Center through MHANYS. The Resource Center is tasked in working in schools, not only to insure that the mandate around teaching mental health in schools is followed, but also to work with schools to insure that school environments are much more conducive to mental health. By in large schools are recognizing that and have led the way to changing school climate around better mental health and wellness ---Wellness recovery rooms, greater emphasis on self-care for both teachers and students and curriculum development around the inclusion of mental health have all been positive steps. Students are much more open about talking about mental health and school administrators and teachers are much more aware of strategies to help advance mental wellness in schools. As we know, much more needs to be done. While young people are incredibly resilient, COVID has had a major impact through increases in anxiety, depression and isolation. There is still as yet unknown traumatic impact for young people. Schools have to be prepared to respond to unmet needs.

Recommendations

» Expansion of School Based Mental Health Clinics. Through the leadership of the NYS Office of Mental Health Commissioner, Ann Sullivan, there has been a large increase in the number of school based mental health clinics. There are over one thousand in New York State to date with more coming. These clinics, on the grounds of schools, are there for students that have mental health needs. While there is clearly a need for more social workers and clinicians in schools, this is a significant response to those students that may have an immediate crisis.

» Teacher Education About Mental Health For many years, legislation has stalled that would create language to insure that teachers had training in mental health as part of their credentials. Teachers have incredibly difficult jobs and the last thing they need is to be mental health clinicians but a basic knowledge of mental health could help mitigate crisis and provide referrals to mental health professionals when needed. In addition, teachers have gone through incredibly difficult times during COVID and there has to be greater opportunities to explore self-care needs.

» College Mental Health College mental health has become a major issue given the impact of the Pandemic. Recent number are devastating. Almost half of college students have a mental health disorder in the past year, 73% of students experience some sort of mental health crisis during college. At MHANYS, we recently published a White Paper that explores what needs to be done in New York State to insure better mental health services in schools.

» Among our recommendations include Whole Health Parity---much like Parity in Insurance Plans, the same would be true across all colleges and universities. People with mental health need would be treated no differently than people with physical health needs around policy of absences, loan repayment, readmission and other policy determinations. Another key recommendation is that students and school personnel should have mental health training that essentially creates level setting so there is an equal understanding of mental health across college campuses. MHANYS is holding a forum around college mental health in October bringing college and mental health professional together. We are hoping that Attorney General James would be able to participate.

988 and Crisis Service

The United States is only a few weeks away from implementation of a nationwide number, 988, that will be the new crisis response line for people in a mental health and/or substance use crisis. The creation of this new number in New York gives us a new opportunity to look at the current crisis system that is in existence. We know that there has not been enough funding for crisis services leaving law enforcement in difficult situations and the person in crisis either ending up in an emergency room or in jail. Utilization of 988 will be significant in hoping to avoid law enforcement engagement or increased emergency rooms visits and we are very appreciative that the Governor has added two years of funding to the program. However, we know that there have to be long term services and support after the crisis is mitigated. This speaks to a robust community services systems that need to be well funded. The same is true of Crisis Stabilization Centers. We think of these Centers as urgent care for mental health and addictions disorders. If someone is in a crisis, 988 will be able to direct them to a Crisis Stabilization Center where they will be treated by a physician, nurse and clinician. It is a great step forward but the Centers will only be able to keep people for 24 hours before discharge so you run up against the same issues of lack of continuity of care throughout the system.

Recommendations

» We wholeheartedly support 988 and Crisis Stabilization Centers but there needs to be funding in place to insure that their services around a plan of care upon discharge is fully funded so that emergent needs are met and services are provided

Fighting the Stigma of Mental Illness

The recent horrific incidents in Buffalo and Texas have been used by some as a rational for saying these acts were driven by mental illness. That is an incredibly simple answer to a very complex problem. While mental health may play a role in a rare number of cases (only four percent of all violent crimes are committed by people with a mental health diagnosis), the most important factors are history of violence, family trauma, domestic abuse and easy access to guns. Other countries across the world have a big if not bigger mental health problem then we do in the United States, yet there are no mass shorting worldwide. They for the most part only take place in the United States. This kind of incendiary language only continues to mythologize mental health and violence. A direct result of which is that people that desperately need mental health services do not receive them for fear of being stigmatized as violent. Throughout the discussion of the expansion of Kendra's Law, we saw the same kind of language that created unnecessary amendments to the existing law. We must do everything in our power to end this stigma.

Recommendations

» Mental Health First Aid (MHFA) is a best practice training that provides individuals with the tools to have a greater understanding about mental health, the signs and symptoms of mental health issues and how to respond to a mental health crisis. To date over two million people in the United State have been trained in Mental Health First Aid. To the credit of Governor Hochul and the NYS Office of Mental Health, there is funding to provide Youth Mental Health First Aid statewide over the next two years. We recommend a full expansion of both Youth and Adult Mental Health First Aid in every corner of the State. These trainings are meant for all members of the public including family member, peers, mental health and health care workers, law enforcement, educators, human service program, etc. Anyone impacted either directly or indirectly by mental health related issues (which is virtually everyone) should be trained on Mental Health First Aid. We urge the support of the Attorney General as a strong voice in support of Mental Health First Aid.

» Statewide Public Awareness Campaign. While there have been stops and starts over the years around public awareness about the stigma of mental illness, there have been very few sustained campaigns. We know they work and work well for tobacco cessation, breast cancer awareness, Alzheimer's and other disease states. We need a sustained public awareness campaign that helps to end this stigma. We urge the support of Attorney General James to help provide her powerful voice in strong support.

Prevention Across the Life Span

As referenced in the beginning of the testimony, there is a need for prevention across the lifespan. At MHANYS, we often talk about all the different parts of life and how there is a mental health component to virtually everything from maternal mental health through geriatric mental health and everything in-between. How we address prevention is by looking across all the sectors and see what we can do to prevent a serious mental health issue. The science and research are there from maternal mental health, children's services, school based services, colleges, veterans' mental health, adult mental health, mental health in the workforce and geriatric mental health. We have the tools and outcome measures to look at this from a lens of public mental health perspective around suicide prevention, family engagement, peer support, links to robust and appealing services, full mental health parity, school based prevention, trauma informed care, full access to mental health medication and mental health literacy, led by a culturally sensitive, well trained and well compensated workforce that understands resiliency and recovery. We just need the funding and will to make this happen. We urge the continued leadership and support of Attorney General James and her staff for helping to positively transform New York's Mental Health system.

Alan Labor / Bronx, New York

Please expand Office of Mental Health certified mental health case managers. It is hard enough to be mentally ill and equally so when faced with maneuvering the system after a mental health crisis. Mental health case managers who can provide one on one care by navigating the social systems, housing, employment, follow up mental health care etc. for those who are affected and recovering from crises will go a long way to alleviate the problem the city faces. As we know, stigma from family and friends is real and pts are left to be "on their own". Case managers play a vital role in ensuring these patients get connected. Studies have shown that developing social skills is paramount in the recovery of mental illnesses.

Elise Woznick / New York, New York

Thank you for taking the time to hold this public hearing on our state's crisis in mental health are. We are writing as a representatives of the Center for Urban Community Services (CUCS)/Janian Medical Care where we act as the Program Director and Psychiatrist for 1 of the agency's 4 Intensive Mobile Treatment (IMT) Programs. IMT is a treatment model designed by the NYC Department of Mental Health in 2016 designed to work with New Yorkers who have been assessed as being high risk for violence in the community and who have had frequent interactions with the behavioral health systems.

The IMT program has had substantial difficulty coordinating with hospitals and securing inpatient psychiatric beds when needed for our program participants since the onset of the pandemic. We work with our clients closely, and often over many years, in the community and have extensive knowledge around their psychiatric history, symptomatology and risk factors. When they enter a hospital's Comprehensive Psychiatric Emergency Program (CPEP) or Psychiatric Emergency Room (ER), we are eager to relay that collateral information to the attending Doctor and treatment team and to advocate for optimal care. However, over the last few years it has become increasingly difficult to contact ER and hospital staff to relay clinical information. Furthermore, it has been our experience that behaviors witnessed by staff in the CPEP or ER are often considered with greater weight than behaviors we report witnessing in the community, even when we are confident that these problematic or dangerous behaviors will resume once the client is released back to the community should effective treatment not be rendered. Clients are frequently released from the CPEP or ERs because there is concern their behavior will be disruptive to the inpatient milieu. If the hospital staff considers the client to be antisocial or to be utilizing the ER for secondary gain, as is often the case with homeless people seeking shelter, underlying medical or psychiatric concerns are often ignored. In recent months, IMT participants that have been preemptively discharged from CPEPs and ERs despite the team's advocacy for admission have continued to cycle into other emergency departments, have been injured, have been arrested and have died. Better coordination and integration of collateral information when considering admission to psychiatric inpatient units would result in better long-term care and may prevent some of these occurrences. We have been told many times that the scarcity of inpatient beds has factored into admission decisions.

In November of 2021, one of our teams received a referral for a program participant that we flagged as being significantly high-risk for danger in the community. Between November and February, the participant was hospitalized 3 times between 2 hospitals. Though the reasons for these admissions were medical, there were precipitating psychiatric factors. Notably, the participant was hospitalized in January after sustaining injuries from jumping onto train tracks while experiencing delusions that he was being chased by gangs and that he was God. The IMT team advocated for psychiatric consultation and advocated for both psychiatric admission and for the participant to be started on a long-term injectable medication. However, each time the participant was cleared medically and discharged without any significant change in the psychiatric treatment plan because acute psychiatric concerns were not observed in the hospital. After the January hospitalization, this participant was discharged suddenly without coordination with our team, and it took several days to locate the patient and to locate his discharge medications. On February 9th, the participant jumped from the 7th story of a building in Queens. They died in a Queens Hospital 2 days later.

In March of 2022, another IMT participant was hospitalized at a hospital in the Bronx after EMS was activated by his residence who observed him behaving in a disorganized and bizarre manner. He was admitted to the inpatient psychiatry unit. The IMT team consulted with the inpatient unit and expressed concern about his change in mental status, confusion, aphasia, and irritability. The team requested a neurology consultation several times. The team was informed on 3/29 that he had been transferred to the medical unit but was not provided with the rationale for the transfer. The team reached out by phone and email to the medical unit to obtain more information and relay concerns about psychiatric and cognitive decline. The team was informed on 4/4 that the client had been discharged from the hospital. There was no discussion about whether the client should be returned to the psychiatric unit. Further, the team was not provided with any information about course of treatment in the medical unit or in psychiatric unit despite requesting discharge paperwork several times. The team eventually filed a complaint with the patient relations department to obtain discharge paperwork. The team was not able to obtain the medical discharge paperwork until 4/13 and the psychiatric discharge paperwork was not provided until 4/19, more than two weeks after his discharge. The discharge paperwork the team was given provided little information and was missing key details, including confirmation that the client received his long-acting injectable

medication. The lack of coordination between the medical and psychiatric units resulted in the client being discharged preemptively, without testing requested by the team and put a vulnerable client at risk. If more psychiatric inpatient beds were available, it may have been easier for the medical unit to transfer the client back to continue receiving psychiatric and neurological treatment he needed.

Allocating more funding for inpatient psychiatric beds should allow hospital staff to be more flexible in considering what factors warrant admission to psychiatric units. Better coordination between hospitals and community providers could reduce incidents of people being discharged when they need more substantial treatment. Many clients in need of psychiatric care have extensive medical comorbidities, and improved systems of communication between medical and psychiatric services would results in better outcomes for people seeking care.

Marianne Gunther / Ridgewood, New York

I am a licensed creative art psychotherapist with extensive experience with children and families facing physical, medical, and psychological trauma. I am tired of having to turn families away from services because. Medicaid, and all insurances, except Cigna, will not pay for my service. Talk therapy is limited, but as we know a picture paints a thousand words.

Christine Steerman / Lima, New York

I have worked as a psychologist in NY since 1981. A number of my cohort retired when the pandemic hit due to the challenges of continuing to work or set up virtual therapy. As I already had this capability, it was not hard for me to switch to online services. The factors for access issues that I am aware of are:

1. Fewer experienced therapists available due to above issue
2. I myself had fewer openings because so many prior clients recontacted me during the pandemic.
3. I heard from some clients of agencies that their agencies closed during the pandemic, leaving them flat.
4. During the beginning of the pandemic many of us volunteered to help out during the crisis i.e., phone calls etc. The second year I did not hear of any of this being available -Therapists became burned out. By the second year I also had to cut back from the high rate I was working during the first year.
5. I have a done a lot of volunteer disaster response and the familiar pattern of stress and difficulties coping increasing as the situation continues was apparent - and yet the extra supports available at the beginning had ended. I expect people could not keep it up long term - pro bono work when they were already overburdened.
6. Co-pays were covered by BCBS which was helpful to those who did not have high deductible plans. Almost everyone I see has a high deductible plan (other than Medicaid option plans). Clients were even less able to pay the deductible than usual and waited too long to contact.
7. Social emotional issues with students who missed important time with their peers multiplied in second year. Lack of access for kids/families worse than for adults.
8. Fear and social climate did not help - isolation when community was needed.

Ellen Stewart / Roxbury, New York

I am a counselor/Art Therapist working at a rural upstate school in the second poorest county in the state, Delaware County. Whenever I need to send a child for inpatient services there is no place closer to send them than two hours away. This is a hardship for families who want to visit their child, and with gas prices skyrocketing, it becomes less of an option. And that is if there is an open bed at any of the facilities that are two hours away, and if they are filled, the child needs to go farther. Sometimes there are no beds available at all. This is unacceptable to the wellbeing of children and families who are struggling. We need to have quality inpatient child and adolescent beds available within a reasonable distance. This has never been more critical than now!

Laurie O'Reilly / Bay Shore, New York

Meaningful, helpful mental health support & services for families, such as crisis response, community respite, skill-building (PSR) are not available in practice, only available on paper. The corporation which administers the taxpayer dollars which fund Medicaid does not allow enough to create sustainable employment models to help families. Here is there 2021 4th quarter report https://investor.maximus.com/news-events/press-releases/detail/491/maximus-reports-fourth-quarter-and-full-year-results-for . I believe this is the base of the problem. Thanks for all you're doing to help families to help themselves.

Gerald Scupp/Barbara Blair – Garment District Allicane / New York, New York

Good afternoon. I am Barbara Blair, President of the Garment District Alliance.

The Garment District Alliance strongly urges the city and state to provide funding to dramatically increase the number of long-term psychiatric beds available to individuals challenged with mental illness.

Quality of life in midtown's Garment District, and in fact throughout the city, is dramatically degrading due to lack of adequate programs for those suffering from mental illness. These people, including those with severe drug addictions, have been abandoned, left to their own devices to survive on our subway system and throughout our public realm. This blatant failure of government is not only inhuman to those in need, but also creates a public health and safety challenge for all users of public space and transportation.

The mentally ill are simply not receiving adequate social services. Even when the services are available, the lack of oversight and accountability of the providers often just exacerbates the problems. Daily, we see individuals in crisis congregating on public streets where they are preyed upon by exploitative drug dealers. Social service providers must be held accountable not only for the sake of the people they service, but to the neighborhoods in which they operate.

Although The Alliance is in favor of developing more supportive housing, the programming must fit the needs of their particular population. Some of the untreated mentally ill simply need more highly supervised housing. There is a strong need for in-patient psychiatric facilities, and this need cannot be addressed through building supportive housing alone.

Additionally, care must be taken by city and state agencies when siting supportive housing and other service providers. Oversaturating an area with providers, like we are experiencing in the garment district, can have a devastating effect. It also creates an unhealthy environment for those being treated. A rational criterion for siting providers and supportive housing, based upon fair share principles, must be implemented by both the city and state.

It is imperative that New York State take action to access much-needed Medicaid funds. Currently, states are prohibited from using Medicaid funds to reimburse stays in mental health facilities with more than 16 patient beds

without a waiver from the federal government, which is a provision known as the exclusion for Institutions for Mental Disease or "IMD Exclusion." Because Medicaid currently excludes payments to IMDs – meaning a hospital, nursing facility, or other larger institution of more than 16 beds – hundreds of psychiatric beds have been repurposed for other uses.

The Alliance therefore asks the Governor's Office, the NY State Health Commissioner, or the NY State Medicaid Director to request an exemption to the IMD Exclusion. New York can apply for a 1115 waiver to expand eligibility and reimbursements for IMDs. As of February 1, 2022, eight states and DC have been approved for these waivers with six states pending. New York must join this list.

The Alliance's locally-elected Senator Brad Hoylman introduced a bill (S.8422) to direct New York State to apply for the Medicaid waiver, but the bill did not receive a hearing in the Assembly during this legislative session. As the bill is now unlikely to advance further until 2023 at the earliest, the Alliance asks for New York State to apply for the Healthy Adult

Opportunity Section 1115 Demonstration Application as soon as possible.

Our neighborhoods need every tool possible to solve the mental health crisis that is manifesting on the streets of midtown. It is unhealthy, unsafe, and unfair not only for those afflicted, but for those who experience the repercussion throughout the public realm.

Anna Ulacia / Bronx, New York

My questions and concerns regarding mental health: as a parent of an adult with mental health issues & substance abuse issues I'm troubled and frustrated at the fact that help is limited because of all restrictions when it comes to trying to get help for a love one your told that the individual in question has to make that call and willing on getting help so I as a parent can't place that call nor see the psychiatrist without consent even though the individual in question have little capacity or can't comprehend what they're consenting to...

1. Not enough facility to provide for long term service (dual)

2. Not all people suffering from mental health are violent we have to devise a plan where I feel should be categorized in levels you can't expect to put non-violent with violent mental suffering individuals there has to be common grounds

3. Better resources to assist individuals with the needs, social workers, intensive case management (ICM) workers, calling clients at the end of the month for the purpose of doing their monthly progress report isn't sufficient help if at that, better training Is needed on all levels to assist the individuals with mental health and abuse to the individuals from staff needs to be looked into.

4. Better facility it's unfair that if you're at a different level financially you receive excellent service but if you're a low in-come person the service is poorly render

5. Screen the employees working within these facilities. My son was sexually assaulted by a staff member that was a pedophile and a rapist of a 12 and 14 year old in the state of Florida, but when the individual was hired here in a state hospital in the Bronx, there was never a background check because someone vouched and looked the other way for the individual to be hire giving this person access to adults with challenges as well as children.

6. As a parent of an adult individual with needs I need getting through the red tape that doesn't allow me advocate for my son without being ignored and hitting roadblocks it's a difficult situation which affects the parent well being too.

Majory Unger / Catskill, New York

I just know that I have mental illness, and that my Medicare coverage pays a lot less for my treatment than for my physical health. And when I recently had a medical hospitalization, I had to advocate for my mental health drugs and even then, they did not provide all my drugs to keep me well. I had to have a friend get my meds from the pharmacy and self-medicate.

Gustavo Rivera / Bronx, New York

Thank you, Attorney General James, for organizing a hearing on an important topic, the Mental Health Crisis in New York State. I'm honored to join stakeholders and members of the community for an opportunity to discuss mental health services being provided in New York State. Public understanding of mental health issues and the care available to those in need of support continues to evolve as more knowledge is gained in the field, but there is much work to be done. Individuals and families facing mental health issues still confront barriers to their care. The pandemic left a lingering miasma of mental strain on all of us. Together we've faced great uncertainty, economic disruption, illness, and death. This has taken a toll on our collective psyche and the result is an increased need for these services by the public at large. On the bright side, our society is becoming more aware of our mental wellness and more open to treatment for mental health issues, when previously it was regarded by some as a taboo subject. I am encouraged that conversations around mental health are becoming less stigmatized. Due to the increased awareness, more people are seeking mental health care. Access is one of the most fundamental barriers that those seeking mental health services face. Issues related to accessing care can be broken into two main categories: availability of the services by providers and an individual's ability to obtain those services. First, providers are facing three main challenges: increased demand; workforce shortages; and reimbursement challenges. While many individuals may not yet be receiving treatment for a diagnosed mental illness, more are tapping into a system of providers that was already limited and is now facing increased general demand. Without a corresponding increase in availability and sustainability of services, we're seeing increased strain on the provider community and reduced availability for those individuals seeking treatment for mental health issues. That brings us to workforce challenges. Projections by the US Census Bureau estimate that our country will see growth in the population over 65 years old for the next 30 years. They're estimating an additional 17 million seniors this decade alone. An increasingly aging population will result in broad and sweeping implications for workforce issues generally and will almost certainly impact the number of mental health providers that are available to deliver services in the future. While the number of providers is likely to decrease, the demand for mental health services will continue to rise as retired workers still need access to these critical services. On top of this, the recent increased strain being placed on providers has created burnout and led people to seek retirement earlier than anticipated or to seek a career change, which has further exacerbated the workforce crisis in the mental health and health care provider community. We have worked to build capacity and create pipelines for careers in the mental health and health job market. We should continue to build that capacity as quickly as possible to address the needs of our residents. A successful model that we have used previously is providing scholarships to individuals in exchange for the new professional offering their services to underserved communities in our state. The third topic on the provider side that has an impact on access is reimbursement. In my time as Chair of the Senate's Health Committee, I've seen the impact that historic underinvestment in mental health care has on our communities, particularly communities of color like those I represent in the Bronx. With many individuals and families receiving health insurance provided by employment, the catastrophic loss of jobs during the pandemic meant that they also lost health coverage. Many individuals turned to Medicaid as a coverage option. The experiences during the pandemic have been a telling example of the perils of having a coverage system that is driven by employer-provided health care. Now, about one in three New Yorkers rely on the Medicaid program, so our state must ensure we have a budget that serves those patients and their providers. The Medicaid budget has been artificially constrained by the 'Medicaid Global Cap.' This cap isa limitation on overall Medicaid spending growth based on metrics that, up until this past budget, did not even include adjustments for increased enrollment. When the former governor enacted the cap, he created a system with predictable outcomes in spending that ignored enrollment growth, service needs, and created artificial pressure on the system. This means he was consistently proposing reducing or cutting Medicaid coverage of necessary medical services or reduced reimbursement to providers. I fight hard during budget negotiations to defend Medicaid and fight cuts to this critical program. Prior to this year, Medicaid rates were reduced to the "lowest accurately appropriate rates possible," a fancy way of saying the bare minimum. I don't, nor should my fellow New Yorkers, accept this as an appropriate way to govern. These rates didn't account for unanticipated costs or shocks to the health care system, which we've seen plenty of in the past few years. They also create stagnation in the industry, which prohibits the exploration of creative solutions to address systemic issues. This past year, we saw Governor Hochul's first budget begin to address this historic disinvestment through amendments to the artificial Medicaid global cap that I fought for to factor in enrollment growth. I want to make clear that I am supportive of eliminating the cap entirely and carry legislation to do so. We need to address how reimbursement rates impact providers. This past budget cycle we finally

made historic investments in Medicaid rates, as opposed to a decade of disinvestment and austerity for critical services. Governor Hochul's enacted budget increased the majority of Medicaid expenditures by 1% and undid some of the previous cuts to the program. While this is a positive change, I am hopeful to see continued and increased investments in Medicaid in future budgets. Many facilities and providers offset losses associated with care for Medicaid recipients and those without coverage by private insurance rates or other subsidy programs. This leaves providers like safety net hospitals, who serve our most vulnerable residents with the least access to mental health care, at particular risk due to their large volume of Medicaid and low-income patients. Providers and their advocates have specifically reached out to me to express concerns as it relates to inpatient psychiatric reimbursement rates for hospitals. Governor Hochul, to her credit, increased funding in February by $27.5M to address this specific issue. However, it should be pointed out that this increase was in the Medicaid fee-for-service space and the majority of inpatient psychiatric services delivered by hospitals are provided through the Medicaid managed care program. While we are finally beginning to right the ship a sit comes to Medicaid spending, it is moving slowly and there are years worth of under investment that need to be addressed. We should build on this momentum and continue New York's investments in Medicaid.While providers grapple with challenges in reimbursement, New Yorkers are struggling with access to mental health services due to limited access to coverage. Even New Yorkers who do have insurance find limitations in their coverage for mental health services. Restricted networks, cost-sharing requirements, and benefit limitations are all ways that I have seen residents of New York struggle to get the services they need. These issues are not simply about a sufficient number of providers for the enrollees of a plan. If an individual lives in a service desert, they may have to travel long distances for services, creating disruptions at home and work and causing individuals to put off seeking care. One of the silver linings to the pandemic is the expansion of telehealth services, which allow an individual to receive mental health and health services where it is most convenient. This past budget included provisions increasing parity for telehealth services. However, telehealth services for mental health issues have lagged behind. I have legislation that would create uniform parity for telehealth services to help providers offer and expand this accessible form of care. While telehealth is not a silver bullet to address the access issue for individuals, and should not be used in all instances, many providers in the Bronx have expressed to me the benefits they've seen for their patients who can receive care without traveling, arranging child care, or leaving the comfort of their homes. Finally, we must address systemic inequities in care for all residents of our state. Studies have shown that minority populations are less likely to receive care for their mental health issues than their counterparts. One of my bills, which both the Senate and Assembly passed and will be delivered to the Governor later this year, expands duties of and renames the Office of Minority Health to the Office of Health Equity. This office would be tasked with promoting social determinants of health to help New Yorkers thrive and to alleviate strains across the system that compound the struggles of individuals with mental health issues. Additionally, it would task the office with advancing measures to promote equity among all populations, including those that have experienced socioeconomic and systemic disadvantages. Fundamentally, all of our communities are strengthened by ensuring and promoting the wellbeing of all New Yorkers.

Ezra Maurer / New York, New York

I am testifying today on behalf of the New York State Nurses Association. NYSNA represents more than 40,000 nurses for collective bargaining and is a leading advocate for universal health care coverage for all New Yorkers. I am a registered nurse with over six years of experience working in in-patient, acute care psychiatric care units. I began working at the Health Alliance Hospital Mary's Avenue Campus in-patient psych unit in Kingston six years ago, but for the last two years I have been reassigned to the psychiatric in-patient unit at the Mid-Hudson Valley Division of Westchester Medical Center in Poughkeepsie due to the closure of the psych units at Health Alliance. I have a personal commitment to working in the mental health field and to providing vital mental health services to the people in my local community. New York is currently experiencing a serious mental health crisis that has been worsened by the stress of the COVID pandemic. In addition, because of a state policy priority to reduce expenditures on acute care beds for the treatment of psychiatric patients, we find ourselves without enough resources and beds to provide the care that our patients need. Since 2000, the state of New York has reduced state psychiatric hospital in-patient capacity by more than 20%. At the same time, public and private hospital psych beds were cut from 6,055 in 2000 to 5,419 in 2018 (12%). The COVID crisis has made the situation worse. The pressures of the crisis have caused an explosion in people needing psychiatric care, including in-patient care, but the State has directed or encouraged hospitals to convert non-critical inpatient beds to ICU and acute care beds to treat COVID patients. This situation gave many hospitals the opportunity or excuse to temporarily or permanently close their psych units and reduce beds. Hundreds of those psych beds remain closed and have not been restored, even though the need for COVID treatment beds is now greatly reduced. In my facility in Kingston, I have personally experienced the impact of the COVID crisis and the ongoing closure of our 40-bed in-patient psych unit and the 20-bed detox unit. On April 2, 2020, we received notice that our psych and detox units would be temporarily closed to serve as emergency COVID overflow units. I and the other staff were then transferred to work at the psych unit of the Mid-Hudson Valley Division of Westchester Medical Center in Poughkeepsie. To my knowledge, our unit was never actually used for COVID overflow patients. Instead, it appears that the building was closed and our transfer to Poughkeepsie allowed the hospital to begin its planned construction of new hospital facilities that are to replace our existing campuses in Kingston. The closure of our 40-bed psych unit eliminated all in-patient psych beds in Ulster County, forcing the 200,000 residents to seek in-patient care at other locations much further away – we are the only hospital in Ulster County with certified psych beds and our census was consistently at 35 or more beds (or at about 80% of capacity). With the closure of our unit, local patients who needed in-patient psych treatment were instead referred or transferred to the Poughkeepsie site (about 40 minutes by car). Others were being referred to the Westchester Medical Center psychiatric units in Valhalla (about 1 ½ hours by car) or to Bon Secours in Port Jervis (about 1 1/3 hours by car). The closure of the psych units in Kingston was a big problem for our patients and their families. The other facilities with psych beds were much further away, required a lot more travel time, and required them to have access to a car to make the trip to visit their loved ones. Many of our patients would travel to the Poughkeepsie site, which was closer to Kingston, to avoid the chance that if they came in through the Emergency Room that they might be admitted and transferred to the units in Valhalla or Port Jervis. They preferred the relatively closer site in Poughkeepsie. The long distances to the alternate sites also lead to a waste of ambulance and transport resources. When a patient is evaluated in Kingston and deemed needing of in-patient service, that patient is then transported via ambulance to Poughkeepsie, Valhalla or Port Jervis accordingly. I have had conversations with the ambulance staff, and they say that when they have to transport to these facilities from their local service area that they are effectively taken out of service for an hour and a half to 2-1/2 hours for the round-trip transport. This takes away from anyone else in the local area who might have to rely on an ambulance for an emergency transport to the hospital for any reason. As I noted earlier, the now closed mental health units in Kingston included a 40-bed acute care psych unit and a 20-bed detoxification unit. The Poughkeepsie site to which we were transferred also operated a 40-bed psych unit and shortly after we were transferred they added 15 psych beds, bringing the total to 55 beds. That means that until our unit is reopened, there are 25 fewer psych beds in the Hudson River region and 20 fewer detox beds. There are currently no in-patient psych beds available for our patients in Ulster County. In addition, it is our understanding that the newly constructed hospital in Kingston will be reducing the current in-patient psych unit capacity from 40 beds to 20 beds – we will have a permanent loss of 20 psych beds in Ulster County when the new hospital building is opened. The state must take immediate action to address the ongoing mental health crisis and to restore psychiatric in-patient capacity to meet the needs of New Yorkers, including the following steps:

» Significantly increase the Medicaid reimbursement rates for in-patient psychiatric care to make them competitive with other procedures;

» Require all hospitals to re-open all psychiatric beds that were "temporarily" closed during the height of the pandemic, with strict timelines and oversight;

» More tightly control the approval process for permanently closing psych units or beds and implement a moratorium on closure applications;

» Seek federal approval to allow Medicaid to reimburse providers of long-term psychiatric care patients;

» Increase the total numbers of psychiatric in-patient treatment beds to comply with generally accepted standards for available beds on a per capita basis.

Andrea Marinelli / Amityville, New York

I'm a credentialed family peer advocate working the last 9 years and have lived experience since 2003. I'm a foster adoptive parent of a sibling group of 3 children with SED's (serious emotional disturbance) In navigating the mental health systems of care for our family and those I serve, have found a lack of services, and long wait lists. My three children ended up in the foster care system due to a mom that had untreated mental health and was drinking and taking drugs during pregnancy. My oldest son expired twice at birth, and his siblings were born pre-mature and all three have medical and mental health diagnoses.

The SPOA children's services changed in 2019 and then followed by the pandemic which has caused longer than usual waitlists for services. The emergency room visits to Stony Brook hospital are not admitting children that have had repeated visits and lack of mental health providers not offering appointments has caused their illness to go untreated and worsening and causing more harm to the child and families. Families are experiencing PTSD and anxiety and a lack of safety. If a child is not admitted after an emergency room visit because they didn't have a plan, suicide shouldn't be the only criteria to get help for the child. Certainly, extreme behavior and or decompensation is a cause for alarm, and on the spot assistance for therapy and medication. The discharge plan must include referrals to providers that can see patients. There is a rise in families living in shelters that are not working with families to get public assistance, and medical and mental health providers to service their families. Several waitlists for evaluations and the lack of providers are just unacceptable. There has been a tremendous turnover of social workers, psychiatrists, and peer counselors. Due to lack of funding being used appropriately, and low salary ranges for service is also impacting services. Family Peer Advocates are taking on increasingly high caseloads and are on the front lines, are not sufficiently paid for the services that are provided. A trained peer with lived experience needs to be valued and compensated for the services provided. It has been difficult to connect youth and family to community resources that cannot offer the services required. The school systems are not equipped to provide adequate trauma, and mental health help. More training and positions must be added to the schools. All children on LI are at risk for drugs, sex traffic schemes, and social media frauds, which are causing increased lack of compliance to rules and mental health compliance. The economy and cost of living on LI is extremely high causing barriers to treatment, and single parents cannot afford mental health providers. Please review and address the points I have presented and come up with plans to help our families.

Judi Tota / Carmel, New York

I am writing to you to give you some information about a very current issue.

As you know, there is much discussion for the urgent need for mental health treatment. There have been many high-profile acts of violence that have been perpetrated by people who have then been discovered or suspected of needing Mental Health Treatment. In addition, there are many non-violent people who are still struggling with their mental health at this time.

Our lawmakers in New York State are truly attempting to address this matter by increasing funding for mental health services. However, there is a piece of the equation that is still missing. For several years, there are not enough providers of mental health services.

I work in Westchester County. We are just outside of New York City. We have a high per capita of educated professionals in many sectors. Yet, there continues to be a serious shortage of providers at all local mental health clinics.

Governor, you currently have on your desk Bill A1171A.

I am asking you to sign this bill that will enable insurance reimbursement for Creative Arts Therapists. This is a group of Mental Health Professionals who are already licensed in the State of New York. It would allow these struggling mental health clinics to hire Creative Arts Therapists and expand their pool of professionals to provide services to New Yorkers who are asking for these services.

Please sign Bill A1171A. Help struggling New Yorkers have greater access to Mental Health Services.

Sebrina Barrett / Clifton Park, New York

Members of the Association for Community Living (ACL) provide community-based mental health housing for more than 40,000 New Yorkers with severe mental illness, who are working toward recovery and independence. I am Sebrina Barrett, executive director of ACL, and am submitting this testimony on their behalf. We thank Attorney General Letitia James for this opportunity and for amplifying the important need for funding, resources and support for mental health.

For years, ACL has advocated for modernization of the mental health housing models, some of which were created nearly 40 years ago. We have compared program costs, workforce demands, and client needs. In short: Since these programs were created, costs have risen substantially; clients need a higher level of care due to multiple co-occurring mental and medical conditions; and we can no longer pay sta a living wage, leading to severe workforce shortages.

Today's residents require 12-15 daily medications, up from one or two in the 80s, and they face multiple co-occurring medical conditions, in addition to mental illness and substance use disorders. We recently surveyed our members to gather information about the growing number of residents in their care who are aging in place - more than 40% of our residents are age 55 and over, and they are experiencing a total of 166 different medical conditions. Of those conditions reported, the most common were hypertension, diabetes, COPD, heart disease, arthritis, cancer and dementia. For most of these individuals, transition to assisted living or a nursing home isn't an option. Nursing homes won't admit residents with a severe mental illness, and even if they would, they aren't able to address ongoing mental health and the substance use disorder needs of the population served.

As the aging population in mental health community-based housing continues to grow, we must equip agencies with the resources needed to care for the residents they have been serving for decades. More than 75% of the housing providers who responded to our survey stated that they are not equipped to assist their residents with their aging medical concerns. They need nursing staff, on-site health aids, ADA compliant space to assist with mobility, additional staff training and increased pay for staff. We are encouraged that the legislature passed a bill to create a temporary commission on aging in place, and we look forward to Governor Hochul signing it, so that we can bring experts together to find solutions that will enable our residents to age gracefully and comfortably in their homes for as long as possible, while maintaining their independence.

Finally, our members have reported a near 25% average staff vacancy rate statewide, with some programs having as much as a 50-60% vacancy rate. Our members also reported the number of staff who couldn't come to work due to illness, vacation, childcare, or other issues. That brought the staff unavailability average to more than 34% - meaning 1 in 3 staff could not report to work - and this was before the Omicron variant impacted the workforce. Our staffing challenges preceded the pandemic, which has only made the situation worse.

Since the 80s, the work has become more challenging, and the pay has diminished. In the 80s, our staff made two to three times the minimum wage. Today, many of our direct care staff make just minimum wage. They can't afford rent, food, childcare, and healthcare - and for the past two plus years, they have

put their lives at risk to care for others. Many of these staff are single parents, are members of the black and brown community, or are otherwise struggling to make ends meet, often having to work more than one job. Our members report that they are seeing fewer qualified applicants, a sharp increase in those applicants not attending scheduled interviews, and senior-level staff are setting aside their normal duties to fill direct care shifts and keep the doors open. This is unsustainable, and while the funding in New York State's final 2022-23 budget is welcome and will help, it is a bandaid. Meeting these challenges will require additional resources for these programs to survive, especially in this climate where unprecedented inflation is stressing an already under-funded system.

While the governor and legislature have made significant investments over the last few years, state funding has not kept pace with inflation and client needs. We are encouraged by their two-year commitment and must continue to see increased funding to right size the system and look forward to your support in our ongoing funding efforts. Not only is funding and supporting mental health housing the right thing to do, it is fiscally smart. Mental health housing is the foundation to recovery, which keeps these individuals off of the streets, and out of our prisons and jails, and homeless shelters—all of which cost exponentially more when using state dollars.

For these reasons, we thank you for continuing to highlight the need for mental health treatment and resources, and we urge your support for continued funding and the creation of the temporary commission on aging in place.

Kimberly Blair, MPH / New York City, New York

Introduction

Good Morning Attorney General Letitia James and members of the Office of the Attorney General. Thank you for holding this space today to hear from peers living with mental health conditions, their loved ones, and the community-based organizations that strive to support peers in their recovery. My name is Kimberly Blair, and I am here testifying as the Manager of Public Policy and Advocacy for the National Alliance on Mental Illness of NYC (NAMI-NYC), a grassroots mental health advocacy organization, and one of the largest affiliates of the National Alliance on Mental Illness. More importantly, I am testifying before you as a peer myself and as a supportive family member to someone living with serious mental illness.

For 40 years, NAMI-NYC has provided free, groundbreaking advocacy, education, and support services to individuals affected by mental illness and is the only organization in NYC to extend these services to their family members, caregivers, and friends, completely free of charge. Our organization does this so that these individuals can serve as a strong support system for their loved ones with mental health conditions.

Today, I would like to highlight findings from a survey ("the ER Survey") our organization, alongside Manhattan Together[1] and a number of other community partners, conducted among people seeking psychiatric services at emergency rooms across New York City and their accompanying support systems (including family members, friends, and caregivers).

[1] Manhattan Together-Industrial Areas Foundation. (2021). *Manhattan Together- Who We Are. Manhattan Together*. Retrieved June 19, 2022, from https://mt-iaf.org

Methods

Launched in September 2019, the goal of the ER Survey was to uncover the experiences of New Yorkers with psychiatric emergency rooms across the City. Our organizations did so by launching two separate surveys. The first survey was the Patient & Consumer survey consisting of twenty-five (25) questions, and the second survey was the Family & Friends Survey consisting of twenty-nine (29) questions. Our organizations distributed the questionnaire with some open-ended questions via electronic format (e.g., SurveyMonkey) as well as via paper format. Researchers also translated the survey into Spanish and Chinese for respondents. Once the survey concluded in January 2020, our organizations then had an external data analyst review our results for accuracy, overarching themes, and limitations.

Limitations

The researchers closed the study in January 2020 due to several limitations accessing psychiatric inpatient settings due to the pandemic. For this reason, we had a smaller sample size and less diversity among respondents than we had hoped. Our organizations plan to launch a second round of the study in the near future and can gladly share those outcomes and results with the Attorney General's Office, as well.

Findings

From our Patient & Consumer Survey results, our research highlighted several themes on what works within the psychiatric hospital setting and what are areas of improvement to ensure equitable access to psychiatric emergency services.

From the patient and consumer perspective, this included:

1. The need for patients to remain with family members.
    a. In our survey, patients allowed to remain with a family member were more likely to say that:
        i. staff gave them emotional support;
        ii. they were treated with respect;
        iii. they would recommend that hospital;
        iv. they were involved in care decisions; and
        v. their confidentiality was protected.
2. The need for shorter wait times in the psychiatric emergency room and better triage protocol.
    a. Shorter wait times (<30 minutes) were associated with an overall positive experience at the psychiatric hospital.
    b. Shorter wait times (<30 minutes) increased the likelihood that the patient would recommend the ER.
3. The need for more follow-up resources and information.
    a. Of those not admitted to the hospital, 62% said they were given no information or referrals to other follow-up care.
    b. Of those who did receive a referral or information, 55% said that information was not helpful and 16% said it was helpful.
4. The need for better training of medical professionals and other hospital staff, as well as better quality care standards and enforcement.
    a. 59% of respondents said doctors and hospital staff did not tell them about their privacy rights.
    b. 23% said that they "disagreed" or "strongly disagreed" that doctors, nurses, and other staff treated them with respect.
    c. Two participants explicitly mentioned mixed experiences with some staff, such as nurses, treating them better than others.

From the family and friend perspective, there was reinforcement of some of these aforementioned themes, and we learned that there was consistency in:

1. The need to reduce long wait times and set better triage procedures.

    a. Nearly 50% of respondents said the patient waited over an hour until intake saw them to establish the reason for their visit.

    b. Nearly 85% of respondents stated that the patient spent anywhere from over three hours to more than three days in the emergency room.

2. There were also several comments about the inadequate size of the psychiatric emergency room (13%), the lack of privacy (15%) and rooms for patients, extensive time spent waiting in the hallway, lack of privacy, and the need to transfer locations to access a bed.

    a. One person stated that their loved one "was kept on a gurney in the hallway of the psych ER surrounded by other patients, being watched by security and with fluorescent lights on for 3 nights and 2 days…"

3. The need for better training of medical professionals and hospital staff.

    a. A majority of survey respondents said they were treated with respect, but only 34% of respondents said, "I would recommend this hospital psychiatric ER to others."

    b. 19% of respondents suggested hospitals improve the experience of families and friends in the psychiatric ER by specifically increasing compassion and respect for patients and/or family members.

Recommendations

Taking into consideration these survey results, as well as our own experience navigating and supporting peers and family members/caregivers with resources, NAMI-NYC has the following recommendations for our State to truly address this secondary pandemic – the mental health crisis.

1. New York State and City need to enforce transparency and accountability in making sure there are enough hospital beds and psychiatric emergency rooms accessible to all New Yorkers, regardless of what neighborhood they live in.

The consolidation and closure of psychiatric hospitals and the removal of psychiatric inpatient hospital beds has been an issue long before the onset of the pandemic. However, since the pandemic, the problem has worsened. Anecdotally, we hear many of our program participants who have had to transfer to other hospitals in Westchester County, Upstate, or in another borough away from their familial and community supports due to long wait times, bed shortages, or lack of personnel available to tend to their crisis. One family respondent stated, "Past experiences have been good, but the fact that this time she was sent [sic] far away was horrible. Round trip commute for us was 5 hours. (2 1/2 hour trip each way!)."

The removal of a person in crisis from their community to receive care is unacceptable. Governor Hochul has publicly committed[2] to bring back the psychiatric hospital beds that were needed for COVID-19 patients during the State of Emergency; however, we do not see the oversight or enforcement of the process, nor is there transparency demonstrating to the public how many of the beds were taken away and how many are now back per hospital setting. We see this as a crucial first step for the State Office of Mental Health in coordination with the New York City Mayor's Office on Community Mental Health and New York City's Health + Hospitals in order to address long wait times and inaccessible emergency mental health care services across our city.

2. All hospitals must revisit and reform their intake and quality care procedures, especially in New York City's metropolitan area, in order to reduce long wait times and further deterioration of the person in crisis.

[2] New York State Office of Governor Kathy Hochul. (2022, February 18). *Governor Hochul announces major investments to improve psychiatric support for those in crisis.* Governor Kathy Hochul. Retrieved June 19, 2022, from https://www.governor.ny.gov/news/governor-hochul-announces-major-investments-improve-psychiatric-su pport-those-crisis

Since our research is specific to New York City hospitals, our organization can only speak to those experiences. Our research findings reveal that there is a serious need to reduce time for triage, evaluation, and admission of people facing mental health crises across our city. Ambulances also need to triage incoming mental health crisis calls better and respond to Tier 1 situations with the same urgency as someone facing a heart attack in order to avoid an individual's state escalating or worsening due to long wait times. We have quotes from the patient ER Survey where individuals preferred to walk to hospital facilities when in crisis rather than call an ambulance or request a mobile crisis team. One respondent stated that they decided to "walk in because it's the best facility in the city even though I should've used an ambulance, I wanted control over my care quality," suggesting that patients may receive less quality care when using ambulances.

One way to address these long wait times is for hospitals to revisit and reform their intake procedures and quality care standards in ways that are informed by our survey results and the perspectives of peers and family members consuming mental health services. Another way is to increase the amount of trained staff available to respond to psychiatric emergencies, including by hiring New York State Certified Peer Specialists who know best how to navigate crisis based on their first-hand experience paired with their formal training.

3. The State and City should rely on and invest in alternatives to psychiatric emergency room settings in order to drive down demand and improve quality care within the hospital setting.

While every mental health crisis is an emergency, not every crisis call warrants the response or services provided by inpatient hospital settings. Crisis respite centers and walk-in mental health clinics are alternative settings to psychiatric emergency hospitals that have the capability to de-escalate and stabilize a number of mental health crises. While many of these crisis respite centers have the capability to respond to crisis calls, they often do not have the capacity due to limited financial support and resources from the state. For example, our colleagues at Community Access, Inc., operate a community-based crisis respite center, that centers peer crisis workers, provides a home-like environment, runs 24 hours/7 days a week and produces stellar outcomes in stabilizing individuals in crisis and connecting them to a continuum of aftercare resources in their neighborhoods.[3] The State and City should rely on expanding access to these community-based models for New Yorkers with serious mental illness, rather than re-inventing the wheel or solely relying on hospitals, which are currently short-staffed and improperly over-utilized. Furthermore, investments in treatment adjacent services, such as the psychoeducation classes and support groups offered at NAMI-NYC, are necessary to reinforce the preventive mental health care needed to avoid crises from occurring in the first place. Funding these services is imperative now more than ever as waitlists to access non-emergency mental health care services keep growing amid the pandemic.

4. Hospitals' consistent engagement with community-based organizations is necessary to provide patients and their loved ones with the education and aftercare resources to improve the continuity of care and reduce recurring crises after discharge.

Patient and family education is imperative before and after a crisis to prevent and reduce the number of mental health crises and, in turn, improve the psychiatric emergency room experience for many waiting for care. Hospitals need to equip caseworkers or peer specialists with a number of community-based organizations and resources to provide patients and supportive loved ones upon discharge. Additionally, hospitals could allow representatives from community-based organizations, such as NAMI-NYC, to come into the hospital setting to provide psychoeducation, support groups and other resources to loved ones while they wait for an individual seeking care and to the individuals themselves, if they are interested, before discharge. Community-based organizations can teach patients and their loved ones alike to set Psychiatric Advance Directives (PAD) before a crisis so that hospitals can better tend to an individual's needs in the psychiatric emergency room setting. NAMI-NYC can also offer an abundance of free courses and support groups to family members so they can learn to better support their loved one navigating crises. Consistent engagement with these organizations is key, though, to demarcate how we can better serve community members to reduce and improve crises.

[3] Community Access, Inc. (2022). *Access the Crisis Residence*. Adult crisis residence. Retrieved June 18, 2022, from https://www.communityaccess.org/connect/blog/499.

5. Listen to family members, caregivers and loved ones and maintain a quiet space for them while they await the patient's evaluation.

While it is important to protect patients' rights and health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), hospital medical professionals should not use HIPAA as a scapegoat to ignore pertinent information from loved ones. Such information could be key in better facilitating the delivery of care to the patient, and thus, improve the patient's overall experience while seeking care in the psychiatric emergency room. From our ER Survey of family and friends we learned that often "family members wanted to give hospital medical staff critical information about the patient's ongoing situation during the admission process and they [the family members] were not allowed to give immediate feedback."

6. Our State needs to commit to a peer-led, non-police response to mental health crisis calls because it is the best first-line response.

One of the main obstacles still in the way of individuals with serious mental illness receiving the appropriate treatment they need is that the police are still serving as first responders to mental health crisis calls. Under New York's current model, the police still respond to nearly 20% of mental health crisis calls dispatched to B-HEARD.[4] These inappropriate, first-response interactions with the police have historically led to the over-incarceration and criminalization of people living with mental illness in our City and State. People in crisis therefore could easily never make it to the psychiatric hospital or the alternative crisis respite center that they need because they are met with handcuffs, or worse. Anecdotally, we know through our work with program participants and with the Treatment Not Jail Coalition that many individuals have had their mental condition exacerbate and deteriorate while waiting for a psychiatric evaluation in our jails and prisons. In fact, nearly half of the population at Rikers Island receives treatment for mental health conditions,[5] and four individuals have lost their lives to suicide this year alone.6 Furthermore, nearly twenty individuals since 2015 have been killed by the New York Police Department when officers served as first responders to their mental health crisis calls.[7]

Such is the reason why NAMI-NYC serves as a plaintiff in *Justin Baerga, et al. v. City of New York, et al.,*[8] a case challenging the NYPD's inhumane and detrimental "Emotionally Disturbed Person (EDP)" policy towards our community members. It is also the reason why we believe that the city's current B-HEARD program needs to be amended and re-envisioned to account for Correct Crisis Intervention Today of NYC (CCIT-NYC)'s evidence-based, peer-led response proposal. The model works by centering peer crisis workers and independent Emergency Medical Technicians (EMTs) as first responders to mental health crisis calls.[9] The City should prioritize adjusting the B-HEARD model to adopt this peer-centered approach, especially in light of the new, nationwide 988-crisis number, which will take into effect this summer on July 16, 2022.[10]

CONCLUSION

For all of these reasons, we hope you consider our testimony and commit to holding relevant agencies and hospitals accountable in ensuring equitable and just access to psychiatric crisis services, including non-hospital alternatives, for New Yorkers living with serious mental illness.

[4] The City of New York. (2021, December 15). Transforming NYC's response to Mental Health Emergencies. FIRST SIX MONTHS OF OPERATION. B-HEARD. Retrieved June 20, 2022, from https://mentalhealth.cityofnewyork.us/wp-content/uploads/2021/12/FINAL-DATA-BRIEF-B-HEARD-FIR ST-SIX-MONTHS-OF-OPERATIONS-12.15.21-1.pdf.

[5] House Committee on Oversight and Reform. (2022, April 8). Oversight Committee urges NYC mayor To Address Mental Health Crisis at Rikers Island. House Committee on Oversight and Reform. Retrieved June 20, 2022, from https://oversight.house.gov/news/press-releases/oversight-committee-urges-nyc-mayor-to-address-mental-health-crisis-at-rikers#:~:text=On%20Rikers%20Island%2C%20nearly%20half,illness%20during%20their%20jail%20stay.

[6] Hu, W., & Ransom, J. (2022, May 8). Man, 25, is the fourth inmate to die at Rikers this year. The New York Times. Retrieved June 21, 2022, from https://www.nytimes.com/2022/05/08/nyregion/inmate-death-rikers.html.

[7] Community Access, Inc. (2022). CCIT-NYC: In Remembrance. Retrieved June 21, 2022, from https://www.communityaccess.org/ccit-nyc-in-remembrance.

[8] Baerga, et al. v. City of New York, et al., Case 1:21-cv-05762-AJN (2021): First Amended Class Action Complaint.

[9] CCIT-NYC. (2021). *Our Proposal: Piloting a Peer-Driven Mental Health Crisis Response Program*. Retrieved June 20, 2022, from https://www.ccitnyc.org/ourproposal.

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