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New York State Attorney General
Public Hearing on Access to Mental Health Care in
New York
June 22, 2022

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

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

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

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

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

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

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

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

25 The Americans With Disabilities Act in

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

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

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

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

21 2014, Governor Cuomo accepted an \$8
22 billion federal medical redesign grant to
23 establish delivery system reform incentive
24 payment program, DESRIP, and created the
25 transportation plan under the Office of Mental

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

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

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

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

21 And so, according to the New York State
22 Office of Mental Health, there are only about
23 3,000 beds at hospital and state institutions
24 across the state and children are not immune to
25 this crisis.

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

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

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

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

1 worse.

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

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

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

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

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

25 And today, we're going to try to get

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 alone" at his street location.

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

7 The absence of appropriate and well-
8 coordinated psychiatric care can lead to poor
9 health outcomes up to and including death as well
10 as increased criminalization of mental illness.
11 This past winter, community members in
12 Manhattan's upper west side repeatedly called 9-
13 1-1 to request help for a homeless woman who was
14 regularly seen laying down in the street and
15 presenting in clear psychiatric distress. In
16 January, she was struck and killed by a car.

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

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

1 psychiatric inpatients sooner.

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

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

15 Thank you for this opportunity to
16 present testimony today.

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

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

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

1 serious mental illness.

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

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

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

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

25 The clinicians agreed to start the

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

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

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

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

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

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

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

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

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

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

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

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

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

25 DR. TONY CARINO: So there's two ways

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

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

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

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

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

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

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

1 psychiatric patients as far as you know?

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

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

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

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

25 ALICE MORRISEY: I would say yes. I

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

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

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

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

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

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

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

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

25 LETITIA JAMES: And were the services

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

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

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

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

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

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

15 NADIA CHAIT: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

20 LETITIA JAMES: Thank you.

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

24 NICOLE McVINUA: Yes, thank you.

25 ABISOLE FATADE: Please proceed.

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

6 Urban Pathways is a nonprofit homeless
7 services and supportive housing provider that has
8 been serving the New York City community since
9 1975. We assist single adults through street
10 outreach, drop-in center services, safe havens
11 and supportive housing. Our supportive housing
12 programs include (indiscernible) licensed
13 extended stay residences and permanent supportive
14 housing.

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

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

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

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

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

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

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

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

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

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

12 LETITIA JAMES: Thank you.

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

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

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

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

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

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

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

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

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

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

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

1 This will help with smooth transition and
2 continuity of services.

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

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

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

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

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

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

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

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

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

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

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

1 VICTORIA PHAM: It's a state waiver.

2 LETITIA JAMES: State waiver.

3 NADIA CHAIT: If I could jump in on
4 that?

5 LETITIA JAMES: Sure.

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

12 LETITIA JAMES: Okay.

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

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

25 NADIA CHAIT: Yes.

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

4 NADIA CHAIT: That's my understanding,
5 yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 NADIA CHAIT: Exactly.

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

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

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

15 LETITIA JAMES: Welcome, Mr. Chair.

16 GUSTAVO RIVERA: Good afternoon, Madam
17 Attorney General.

18 LETITIA JAMES: Good afternoon, sir.

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

25 You have a more detailed testimony

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 LETITIA JAMES: And Mr. Chair, are you

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

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

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

25 GUSTAVO RIVERA: I believe so. There

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

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

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

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

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

7 GUSTAVO RIVERA: Thank you
8 (indiscernible).

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

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

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

15 LINDA LEE: Yes.

16 ABISOLE FATADE: Okay, thanks. Please
17 proceed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 and also the clinics and especially the
2 outpatient cares.

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

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

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

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

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

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

25 And so, that's something that I just

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

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

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

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

1 from one another.

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

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

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

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

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

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

3 (Audio skip)

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

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

17 LINDA LEE: Yes, it does.

18 LETITIA JAMES: Very good.

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

22 LETITIA JAMES: That was my next
23 question.

24 LINDA LEE: Yeah.

25 LETITIA JAMES: Any other questions?

1 Thank you, Madam Chair.

2 LINDA LEE: Thank you.

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

7 ALICE BUFKIN: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 LETITIA JAMES: Thank you so much.

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

25 RON RICHTER: Good afternoon Madam

1 Attorney General and others.

2 LETITIA JAMES: Hello, Commissioner.

3 It's great to see you.

4 RON RICHTER: Nice to see you, too.

5 So, I am here on behalf of JCCA, which is a large
6 children and family services organization
7 celebrating its 200th anniversary of serving New
8 Yorkers, and in particular has a therapeutic
9 foster care program and a residential campus in
10 Westchester where we serve children that are
11 particularly high needs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 LETITIA JAMES: Thank you.

15 ABISOLE FATADE: Thank you. Please
16 proceed.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 asked.

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

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

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

25 So some of it is about budget decisions

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

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

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

1 not limited to pediatric patients?

2 ALICE BUFKIN: Not adequately, no.

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

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

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

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

1 order?

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

6 LETITIA JAMES: Thank you.

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

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

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

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

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

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

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

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

25 ALICE BUFKIN: I think so, yes.

1 LETITIA JAMES: Okay, okay.

2 RON RICHTER: I'm not sure.

3 LETITIA JAMES: Okay, thank you. Any
4 questions from the panel?

5 JENNIFER LEVY: I just --

6 GINA BULL: Go ahead.

7 JENNIFER LEVY: No, you go.

8 GINA BULL: Mr. Richter, I wanted to
9 ask if you are aware of any parents who have had
10 to voluntarily place their children in foster
11 care in order to get their children adequate
12 mental health services, inpatient care?

13 RON RICHTER: I am not personally aware
14 of any, but I am aware that that is a challenge
15 for some parents and that they have sought
16 placement through the voluntary system in child
17 welfare in order to get the right placement for
18 their kids. So, I could probably find you a
19 parent or two. I don't personally know a parent
20 that's done that.

21 LETITIA JAMES: So let me just say this
22 to the audience. If anyone surrenders their
23 child to the childcare system in order to get
24 services, please contact our office. If they
25 believe that the only way to get mental health

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

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

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

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

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

5 LETITIA JAMES: More acuity.

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

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

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

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

24 DR. ASHWIN VASANA: I have, yes.

25 ABISOLE FATADE: Thank you. Please

1 proceed when you're ready.

2 DR. ASHWIN VASAN: Okay.

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

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

9 LETITIA JAMES: Thank you for being
10 here.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 workers and expanding access to care.

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

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

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

24 Social infrastructure includes places
25 where people can build community and social

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

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

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

25 Our continuous engagement between

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

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

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

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

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

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

19 We're excited about this unprecedented
20 renewed and intergovernmental focus on mental
21 health, particularly from the federal government,
22 and have been working hand in hand with the Biden
23 administration and our state partners on these
24 priorities, including the rollout of the new 9-8-
25 8 crisis hotline.

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

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

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

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

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

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

1 Maloney with respect to the IMD exclusion that
2 you mentioned?

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

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

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

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

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

25 DR. ASHWIN VASAN: We're very grateful

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

4 LETITIA JAMES: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

24 LETITIA JAMES: Yes.

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

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

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

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

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

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

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

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

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

1 they need someone to talk to.

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

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

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

25 LETITIA JAMES: And it's the state

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

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

10 LETITIA JAMES: Thank you.

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

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

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

10 GINA BULL: Thank you.

11 LETITIA JAMES: Thank you Commissioner.

12 DR. ASHWIN VASAN: Thank you.

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

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

25 With an estimated 40 to 50 percent of

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

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

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

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

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

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

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

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

1 York State.

2 Next witness.

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

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

8 SABINA KAHN: Yes.

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

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

15 LETITIA JAMES: Afternoon. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 days before discharge. It's really important.

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

17 LETITIA JAMES: Thank you.

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

20 GEOFFREY BERMAN: Good afternoon.

21 LETITIA JAMES: Good afternoon.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 LETITIA JAMES: Thank you.

20 SABINA KAHN: Good afternoon.

21 LETITIA JAMES: Good afternoon.

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

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

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

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

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

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

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

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

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

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

25 Counseling, intensive care management,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 HARVEY ROSENTHAL: Absolutely.

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

16 GEOFFREY BERMAN: (Indiscernible).

17 LETITIA JAMES: I'm sorry?

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

20 LETITIA JAMES: In both houses?

21 GEOFFREY BERMAN: Both houses.

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

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

3 LETITIA JAMES: Was there a hearing on
4 the bill?

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

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

18 Simply putting somebody in the hospital
19 for 30 days to be psychiatrically hospitalized
20 and then discharged to a shelter and expected to
21 make an appointment halfway across town with a
22 28-day supply of medication is completely
23 inadequate.

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

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

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

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

15 HARVEY ROSENTHAL: Yes, I did.

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

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

1 able to deescalate the situation.

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

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

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

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

1 LETITIA JAMES: 140?

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

4 LETITIA JAMES: Statewide?

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

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

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

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

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

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

25 LETITIA JAMES: Thank you for your

1 testimony. I appreciate it. Thank you, all.

2 HARVEY ROSENTHAL: Thank you.

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

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

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

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

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

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

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

1 and that demands our attention.

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

10 I'll start out with the crisis
11 response. Traditionally if a family needed help
12 they would call 9-1-1 and police officers would
13 come. In the last seven years in New York City,
14 19 people have been killed in such interactions.

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

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

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

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

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

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

12 Next, there's the hemorrhaging of
13 inpatient psychiatric beds. Manhattan lost about
14 450 inpatient psychiatric beds in the decade
15 preceding the pandemic, and then during the
16 pandemic the rules that govern this so-called
17 certificate of need structure were suspended for
18 emergency reasons and we lost many more beds.

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

1 traditional medical purposes, and we have to fix
2 that.

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

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

14 Finally, supportive housing. This
15 topic was just discussed. The estimate in New
16 York City is in need of 86,000 supportive housing
17 units. We have 32,000 today. Add up all the
18 units that are in the pipeline from the state and
19 the city, that will get us to a little over
20 50,000, still leaving a gap of over 30,000. So,
21 while we have made progress, we have so much more
22 work to do to meet the needs for all New Yorkers
23 who need supportive housing.

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

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

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

8 MARK LEVINE: Okay, thank you.

9 LETITIA JAMES: Focusing on those four
10 issues.

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

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

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

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

20 ERIC BOTTCHER: Thank you.

21 LETITIA JAMES: -- I'm way behind.

22 ERIC BOTTCHER: Thank you very much.

23 LETITIA JAMES: Thank you, Council
24 member.

25 ERIC BOTTCHER: I want to begin,

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

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

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

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

25 With the stroke of a pen, a president,

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

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

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

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

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

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

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

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

6 This bill would amend the Social
7 Security Act to allow facilities with more than
8 16 beds to receive Medicaid funds and require
9 them to meet nationally recognized, evidence-
10 based standards for mental health and substance
11 use disorder programs.

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

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

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

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

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

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

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

12 ERIC BOTTCHER: Thank you very much.

13 LETITIA JAMES: Great to see you.

14 ERIC BOTTCHER: Likewise.

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

19 ALISON BURKE: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 LETITIA JAMES: That's a state rule?

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

21 ABISOLE FATADE: Leonidas Bell, please
22 proceed.

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

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

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

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

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

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

25 LETITIA JAMES: Somehow this reminds me

1 of the whole nursing home --

2 LEONIDAS BELL: Yes, it does, indeed.

3 LETITIA JAMES: -- debacle.

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

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

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

3 LETITIA JAMES: We're examining our
4 options.

5 LEONIDAS BELL: So I apologize, I went
6 a little bit longer. I would like to just say --
7 just to wrap up, I think, you know, we've made
8 mention about the need to increase Medicaid
9 reimbursement rates, but you need to consider in
10 that increasing Medicaid reimbursement rates when
11 we're talking about such a wide range of
12 potential income revenues or income streams, you
13 know, you could double the Medicaid reimbursement
14 rate for inpatient care. It would still only be
15 200,000 per year or 150,000 per year versus 1.6
16 million per year.

17 LETITIA JAMES: Right.

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

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

1 approach.

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

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

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

20 LETITIA JAMES: Well, they can issue
21 another waiver.

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

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

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

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

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

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

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

12 I apologize profusely for going way too
13 long.

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

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

18 LETITIA JAMES: Thank you.

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

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

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

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

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

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

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

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

25 ALISON BURKE: So, I do not personally

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

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

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

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

1 between public versus private? What are your
2 thoughts?

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

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

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

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

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

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

11 LEONIDAS BELL: Is that addressed to
12 me?

13 LETITIA JAMES: Either or -- either/or.

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

21 LETITIA JAMES: Yeah.

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

1 looked at last night before coming to today's
2 hearing. But it only tracks licensed beds. It
3 doesn't track actually staffed beds or operating
4 beds. So, one of the issues is that there tends
5 to be overstatement of the number of beds that
6 are actually out there, especially in the Article
7 28 hospital setting, because you know, a hospital
8 may have 40 beds listed but they're actually only
9 really staffing it at 20.

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

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

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

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

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

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

14 LETITIA JAMES: COLA.

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

25 JED WOLKENBREIT: Just one other

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

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

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

18 JED WOLKENBREIT: Exactly.

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

22 JED WOLKENBREIT: Exactly. Exactly.

23 LETITIA JAMES: Thank you all.

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

1 LETITIA JAMES: Yeah.

2 ALISON BURKE: Can I just add one
3 thing?

4 LETITIA JAMES: Yes. Yes, Mr. Burke.

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

13 LETITIA JAMES: Right.

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

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

20 LEONIDAS BELL: Thank you.

21 JED WOLKENBREIT: Thank you.

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

25 GABRIEL VALLES: Maybe. Somebody told

1 me I had to be sworn in (indiscernible).

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

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

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

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

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

25 GABRIEL VALLES: As of today, they

1 haven't been returned. However, there was an
2 announcement they were going to return 20 of our
3 60-some beds.

4 LETITIA JAMES: When did you get that
5 announcement?

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

8 LETITIA JAMES: Okay.

9 GABRIEL VALLES: Now, I'd like to point
10 out though that the removal of beds was back in
11 2020. This is a two-year process, and it wasn't
12 initially even going to be encouraged by
13 Westchester themselves, right?

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

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

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

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

15 LETITIA JAMES: Were they repeat
16 visitors?

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

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

25 GABRIEL VALLES: Not anymore, I don't,

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

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

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

1 day ask these people to --

2 LETITIA JAMES: That's a great
3 metaphor.

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

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

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

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

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

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

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

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

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

10 Unfortunately, there are no beds.
11 We're not sending people 15 minutes away from
12 home. Our nearest bed once you get out of our
13 area is 45 minutes away. The next nearest bed is
14 1-and-a-half hours away. So we're asking the
15 people at the lowest socioeconomic status to now
16 find support that can come visit them as many as
17 2-and-a-half, 3 hours away.

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

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

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

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

11 LETITIA JAMES: Thank you, Mr. Valles.

12 GABRIEL VALLES: Thank you.

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

18 MICHELE ROSELLO: Yes, we have.

19 ABISOLE FATADE: All right, thank you.

20 MICHELE ROSELLO: Thank you.

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

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

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

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

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

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

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

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

4 Leticia?

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

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

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

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

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

14 The state long divestment for mental
15 health services has hurt the ability of New
16 Yorkers to access appropriate services quickly
17 and efficiently. The Office of Mental Health has
18 reduced inpatient beds substantially -- I'm
19 sorry. Excuse me -- stabilization capacity for
20 adults, youth, and forensic patients by more than
21 2000 beds since 2016.

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

1 2020 alone caused New Yorkers 157 million in
2 overdue -- I mean overtime alone.

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

9 Even in the state of reinvestment
10 savings for the reduction of private operation
11 providers, the state's overall inpatient bed
12 capacity still does not meet the basic minimum
13 standard prescribed by the treatment advocacy
14 center, which recommends 50 beds per 10,000
15 Residents in New York. It's short by more than
16 1700 inpatient beds.

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

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

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

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

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

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

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

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

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

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

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

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

8 CARL ANKRAH: AC teams.

9 LETITIA JAMES: AC teams.

10 CARL ANKRAH: Right.

11 LETITIA JAMES: Was privatization?

12 CARL ANKRAH: That's correct.

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

15 CARL ANKRAH: That's correct.

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

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

25 LETITIA JAMES: Why were some of these

1 teams suspended? You don't know?

2 CARL ANKRAH: Reasons beyond our
3 understanding.

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

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

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

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

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

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

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

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

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

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

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

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

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

6 LETITIA JAMES: Yes, Leticia.

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

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

21 CARL ANKRAH: Thank you.

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

1 ABISOLE FATADE: Julie Leclaire?

2 LETITIA JAMES: Yeah. And Roy and
3 Lucille.

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

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

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

13 LETITIA JAMES: I apologize for the
14 lateness.

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

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

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

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

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

1 Something needs to happen.

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

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

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

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

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

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

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

25 I heard nurses threaten 30-minute

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

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

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

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

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

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

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

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

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

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

5 TAMARA BIGUEL: Mountain Lake Academy.

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

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

17 LETITA JAMES: Yeah.

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

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

24 TAMARA BIGUEL: Yes.

25 LETITA JAMES: First of all, let me

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

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

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

13 TAMARA BIGUEL: Yes, I have.

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

17 TAMARA BIGUEL: Okay. I have the
18 backup documentation.

19 LETITA JAMES: Thank you. Thank you so
20 much.

21 TAMARA BIGUEL: Thank you.

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

1 LETITA JAMES: Sorry for the wait.

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

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

7 LETITA JAMES: Good evening.

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

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

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

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

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

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

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

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

1 strongly disagree that doctors, nurses, and other
2 staff treated them with respect. From the family
3 perspective, a majority of respondents said that
4 they were treated with respect but actually only
5 34 percent said I would recommend this hospital
6 psychiatric E.R. to others.

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

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

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

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

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

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

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

15 LETITA JAMES: How many people were in
16 this survey?

17 KIMBERLY BLAIR: It was nearly 60.

18 LETITA JAMES: 60, okay.

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

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

24 KIMBERLY BLAIR: Correct.

25 ABISOLE FATADE: Lucille, take a seat.

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

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

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

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

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

18 LETITA JAMES: The warm line, okay.

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

1 a mental illness called body dysmorphia.

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

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

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

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

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

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

1 the medical issue.

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

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

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

25 LUCILLE ETTERE: Thank you.

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

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

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

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

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

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

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

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

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

17 LETITA JAMES: My sympathy to you and
18 your family.

19 LUCILLE ETTERE: Thank you, very much.

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

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

24 ABISOLE FATADE: Thank you.

25 JULIE LECLAIR: Okay, well, thank you,

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

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

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

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

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

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

22 And so, that's where she ended up. And
23 in fact over 60 percent of those with a mental
24 illness in New York State, who are incarcerated
25 in jails and prisons do have mental health

1 issues, and also many of those who are homeless
2 on the streets also have mental health issues.
3 And in fact, many times when my daughter would
4 become manic, she would become fixated on
5 becoming homeless and would want to run away onto
6 the streets and live on the streets.

7 And my daughter did do very well with
8 her hospitalization. She next had a purely
9 psychiatric one. In her case, she was very
10 lucky, her charges were dropped and she was able
11 to go forward and she went on to have other
12 hospitalizations, mainly for mania, but a few of
13 them were also for depression, one for a very
14 serious suicide attempt. And sometimes when she
15 was admitted to emergency rooms, there were no
16 hospital beds that they could find and they had
17 to really look. So, one time she went all the
18 way from a New York hospital bed emergency room
19 to Connecticut, and she was very lucky to even
20 get that bed in Connecticut because otherwise she
21 would have been released in an unsafe state of
22 mind.

23 And all these hospitalizations really
24 made a difference for her. And what ended up
25 happening is, it was a beautiful thing, but she

1 did not get to finish college before she died.
2 But New York University post humorously gave her
3 a college degree and hopefully from up in heaven
4 she can see it, and her degree is hanging in her
5 bedroom on her wall. And what ended up happening
6 at her funeral is that many people came to the
7 funeral and I didn't realize it, but they came up
8 to me and they were actually people who
9 overlapped with her on psychiatric inpatient
10 units.

11 And they came up and told me, one of
12 them said to me for example your daughter was
13 like a tortured soul sent down from heaven and
14 she uplifted me and many of the other people told
15 me she uplifted their spirits too. And even in
16 the throes of mania, my daughter was able to make
17 a difference on the psychiatric units and one
18 girl who couldn't make it to the funeral who also
19 overlapped with my daughter on the unit flew all
20 the way out from California and it ended up being
21 a snowstorm. So, we drove her to my daughter's
22 gravesite. The girl pulled out a seven-page
23 letter to read to my daughter Alix and she said
24 to her she was now taking medical school classes,
25 that she wouldn't be where she was if it wasn't

1 for my daughter.

2 That my daughter rescued her from some
3 sort of darkness, and that she was going to name
4 her first child after Alix. And then what ended
5 up happening is, I really realized that at that
6 funeral not only had I seen how much difference
7 the hospital made for my daughter, but it made a
8 difference for all those other women who did
9 survive and had a sense of camaraderie and
10 support and getting medication and treatment from
11 being in hospitals together and also what they
12 got individually.

13 And I'm here to say that I really think
14 it's important to have enough hospital beds and
15 that can help avoid being incarcerated, being on
16 the streets, and also ending up dead. And I want
17 to thank you for giving me the opportunity to do
18 this testimony and most importantly, to give my
19 daughter a voice even from beyond the grave. So,
20 thank you.

21 LETITA JAMES: Thank you, Ms. Leclair.
22 And again, our sympathies to you and to your
23 family, but your daughter is smiling right now
24 with her degree. Mr. (indiscernible), you --
25 tell me a little bit about the warm hotline.

1 ROY ETTERE: It's a number -- I'm
2 sorry, thank you for having us. Thank you for
3 seeing us today. Thank you for putting in
4 overtime for that. Thank you. The warm line is
5 a number that is on our website that if somebody
6 needs help if somebody needs to be directed
7 somewhere similar to 988 that's coming in July,
8 I'll try to recommend a service for them. Most
9 of the phone calls are just listening to them.
10 They want to have somebody to talk to, they want
11 to have somebody to vent with and that's probably
12 80 percent of the phone calls. The others are
13 the disappointing phone calls that I can't give
14 them somebody that's going to react in a week or
15 two or three. There's actually three and six
16 month wait lists for these people. How do they
17 get help? The system is lacking. They certainly
18 fell short of what they were designed to do. it
19 seems like the health care system for mental
20 health is not even broken because something had
21 to be in place to break, that something was never
22 there.

23 The warm line as much as it's intended
24 to do good, doesn't. So, one of my questions
25 about the health care, there's -- this is 2019.

1 There was \$225 billion dedicated and lost from
2 lost work. Mental health care services, in
3 patient, that's a lot of money. Why a larger
4 portion can be given to the healthcare workers'
5 salaries, to the therapist salaries, they are so
6 underpaid that nobody's going into the industry.
7 Most of the psychiatrists and psychologists today
8 are over a certain age, there's no attraction for
9 anyone to join into it. We met with NAMI four
10 months after my daughter passed, and we wanted to
11 do something to not have her death just be
12 another death of 46,000 people that commit
13 suicide. That's over a million attempts. 46,000
14 completions. That's 120 deaths per day.

15 I had asked NAMI New York State, a
16 Boeing 747 plane can hold 400-600 people. Based
17 on 46,000 deaths a year, that would be a Boeing
18 747 crashing every week with every other week.
19 two of those planes crashing. I'm not sure what
20 airline it was last year that shut down the
21 entire airline because two planes crashed. What
22 would be the effect if 52 and 25 -- if 75 Boeing
23 aircrafts crashed, what attention would be given
24 to that? Similar attention if not more should be
25 given to mental health. It's not something they

1 want to do, people that commit suicide. They
2 have to do it.

3 LETITA JAMES: Right.

4 ROY ETTERE: They have to eliminate the
5 pain their in. And that's -- that's it in a
6 nutshell --

7 LETITA JAMES: Where do you refer them?

8 ROY ETTERE: I'm sorry?

9 LETITA JAMES: When they call you,
10 where do you refer them?

11 ROY ETTERE: I refer them to MHA in
12 Putnam County because this is part of the Putnam
13 County board that I'm on. I refer them to an
14 organization called Cove Care. They're also in
15 Putnam County. 211, another number for immediate
16 attention and I always tell them 911. If it has
17 to come to a point where you need, you think
18 there's a threat to the person or to you, please
19 dial 911 and explain to the officer why you're
20 calling him.

21 Don't you say 911 come to my house.
22 Because they may come with guns drawn, without
23 that warning, they're coming skeptical. They
24 don't know what they're going to find on the
25 other end. So, there's a lot of training of the

1 police in the counties that were at about this
2 and I'm sure it's throughout New York State. But
3 we were so upset with the system. We built a
4 park, a park of Remembrance Garden, that Senator
5 Harckham, Senator Sue Serino, the county
6 executive and the health commissioner of Putnam
7 allowed us to do it on their property and now we
8 dedicated it, so heartfelt. He said that this
9 garden is placed here in the public eye for a
10 reason. The reason that I wanted to build more
11 throughout New York State, which we're doing now.

12 We have as a matter of fact, as soon as
13 I'm done here, a Westchester County Zoom meeting
14 and we have one in Dutchess County. Putnam
15 County is completed and the reason we want to do
16 these is for people to say, what are these things
17 popping up all over the place?

18 LETITA JAMES: Yeah.

19 ROY ETTERE: And maybe make some people
20 aware what's going on and that suicide should not
21 be handled the way cancer and unwed pregnancies
22 were in the fifties and sixties. It's just not
23 something to be ashamed about. It's something to
24 be addressed.

25 LETITA JAMES: Thank all of you for

1 giving your stories. I truly appreciate it.

2 ROY ETTERE: Thank you for your time.

3 LETITA JAMES: And thank you so much.

4 Bless you all. Thank you.

5 ABISOLE FATADE: I'd now like to ask
6 Martin Colavito, (indiscernible), and Thank you
7 Hewit to come up please. Thank you for your
8 patience.

9 LETITA JAMES: Thank you.
10 (Indiscernible) do we have another panel after
11 this?

12 ABISOLE FATADE: I hope you've all been
13 sworn in, in the green room? Have you guys all
14 been sworn in? Okay, thank you.

15 LETITA JAMES: I apologize for the
16 lateness of the hour.

17 ABISOLE FATADE: Martin, whenever
18 you're ready, please proceed.

19 MARTIN COLAVITO: I want to start by
20 saying, I agree with everybody who's been up
21 here, okay. But I'm going to give a perspective
22 from a rural county, and I have two asks at the
23 end of it.

24 LETITA JAMES: Yes, sir.

25 MARTIN COLAVITO: So, thank you for

1 listening to me. Thanks for having us. My name
2 is Martin Colavito and I'm a resident of Sullivan
3 County, New York and I'm a part of a Grassroots
4 Community Coalition called Sullivan Allies
5 Leading Together (indiscernible). And we're
6 comprised of community members and Boots on the
7 Ground, human service providers. We organized
8 about 7.5, 8 years ago. I have several-hundred
9 members as a part of the overall coalition.
10 We're a diverse partnership of agencies and
11 community resources committed to improve the
12 quality of life for the residents of Sullivan
13 County, New York.

14 Before -- even before COVID access to
15 mental health services in Sullivan County had
16 been a challenge at best and non-existent for
17 many as most -- for many at most due to access
18 issues where rural county people just cannot get
19 to services.

20 As a community coalition, SALT members
21 are an integral part of many of the efforts.
22 They're trying to address the current mental
23 health crisis that is affecting our county. I
24 want to stop for one second and basically say
25 that the county commissioner of health and family

1 services is doing incredible work in the county.
2 We're just -- we're just under resourced. For
3 over a year, we've been a part of the police
4 reform efforts in Sullivan County.

5 We actually drafted the template that
6 all of the police departments used to submit on
7 April first of last year. A constant thread
8 during our conversations with the police
9 departments over the past two years has been
10 number one, they're being asked to become mental
11 health professionals. We've all talked about
12 that before, but the other -- the other issue,
13 especially in the village of Monty Sullivan,
14 Sullivan County, they've been consistently
15 operating with less than half staff.

16 Capitalize, the building that they work
17 in, has holes in the walls where vermin get in.
18 We had a police reform meetings where rain was
19 coming through and if police officers start the
20 day in those conditions with that type of kind of
21 attitude, you know, how do they end it - how do
22 they end the day, you know what I'm saying? You
23 know, officers are asked to kind of triage
24 situations with people who are suffering 24 hours
25 a day, seven days a week. Though there are

1 consistent efforts to address mental health
2 crisis in our county. Sullivan County resources
3 are compromised by the lack of available mental
4 health and substance use disorder professionals
5 who regularly leave our county for better wages
6 and surrounding county. I know everybody's
7 talking about funding and the need to, you know,
8 pay folks livable wages, but Sullivan County, you
9 know, health ranking wise, we're the 61st
10 unhealthiest County in New York State.

11 People who are able to become certified
12 people who are able to treat others because they
13 need livable units -- livable wages leave. All
14 right, speak to our mental health commissioner,
15 speak to two Aileen Gunther, who is our
16 assemblywoman and she'll tell you and they will
17 tell you that people leave our county in droves,
18 leaving us incredibly under resourced to treat
19 this problem, all right.

20 From my experience as a community
21 member along with numerous acquisitions of
22 qualitative data, I can tell you that many people
23 have become accustomed now to not being served,
24 all right? One of our mottoes with SALT is hope
25 is always in the room, but the trick is to get

1 you to that hope. All right, so, as community
2 members, we try to do that.

3 But people are just accustomed to not
4 being considered and that scares us and it
5 worries me as a father, a grandfather, and a
6 neighbor. Okay? The constant narrative from
7 clinicians is that there is incredible pressure
8 to comply with satisfying the required billable
9 units of services that funding sources mandate.
10 These folks are incredibly overworked. It's not
11 uncommon for one clinician to have over 400
12 clients in Sullivan County and that's not
13 counting the people that can't get the services,
14 all right? I personally witnessed people on hold
15 for hours trying to arrange transportation for
16 service so they can attend mental health
17 sessions. Many give up and have their condition
18 conditions exasperated. That was the case before
19 COVID, and it's become exponentially worse now,
20 all right.

21 From March 16, 2020 until now, SALT
22 members have been reaching out to those who are
23 truly compromised due to mental health and
24 substance use disorders. I do believe in my
25 heart that many of the providers in the county

1 and the county itself is doing the best they can,
2 but we are just stigmatized by the population by
3 the amount of people who live in Sullivan County
4 and rural counties. I attended a regional
5 meeting with those charged with providing
6 resources for physical and mental health
7 disorders and I was told that there's not enough
8 livable bodies in Sullivan County to justify more
9 resources.

10 You know, I have grandchildren who I
11 love more than me, you know, I love everybody in
12 here's children, you know, more than me and I'll
13 never forget that. I'll never forget that, you
14 know, and that narrative again, if you speak to
15 our county manager, if you speak to our
16 commissioners, they will tell you they're faced
17 with that all the time, all right?

18 There are no community health workers
19 in Sullivan County, and in rural counties that is
20 needed more than anything, you know, a fella said
21 something before about engagement and it kind of
22 went really quick, but that is the key. What we
23 do as a community coalition is numerous times a
24 month, we hit the roads, we hit the back roads,
25 we hit the communities.

1 We've developed a navigational service
2 that that that defends and will not compromise
3 confidentiality, but seamlessly navigates people
4 to care, and that's in collaboration with the
5 county, all right? But what I'm trying to say
6 is, is counties like Sullivan more than urban
7 counties, need community health workers to get
8 out there, engage people and have that connective
9 tissue with the people who are going to provide
10 hope. I appreciate being a part of this. I
11 really, really do. And in conversations I've had
12 before with folks in the state, I would ask two
13 things. Number one, you know, start to kind of
14 shift the paradigm in regard to service rural
15 counties, all right? And number two, you know,
16 if you guys want to come up, we'll give you a
17 tour, I'll buy you a cup of coffee. We'll have a
18 conversation and we'll be able to kind of start
19 some really good stuff. But again, I'm begging
20 you to consider that rural counties, you know,
21 need help as much, if not more than urban
22 counties. We all need help. Thank you very
23 much.

24 LETITA JAMES: I look forward to coming
25 up to Sullivan County and I look forward to you

1 buying me coffee.

2 MARTIN COLAVITO: I make very good
3 coffee's, I'll buy you one too.

4 LETITA JAMES: I'm going to hold you to
5 that.

6 MARTIN COLAVITO: Well, thank you very
7 much.

8 LETITA JAMES: Is SALT a volunteer?

9 MARTIN COLAVITO: It's a community-
10 based coalition. We started it seven years ago
11 because of the abject need to navigation for
12 service in our county. You know, our overall
13 goal is to compassionately and considerably
14 navigate people to service and I know I'm running
15 over, I apologize.

16 LETITA JAMES: That's okay. Ryan,
17 let's make sure we get coffee, okay?

18 MARTIN COLAVITO: Thank you, very much.

19 LETITA JAMES: Thank you, sir. Yes,
20 ma'am.

21 EVELYN GRAHAM-NYAASI: Good afternoon.
22 My name is Evelyn Graham-Nyaasi, and I'd like to
23 thank you for allowing me this opportunity to
24 testify.

25 LETITA JAMES: I apologize for the

1 lateness.

2 EVELYN GRAHAM-NYAASI: Hm?

3 LETITA JAMES: I apologize for the
4 lateness.

5 EVELYN GRAHAM-NYAASI: It's okay. I'm
6 an advocacy specialist and I work at Community
7 Access. I'm also a steering committee member of
8 Correct Crisis Intervention Today, New York City.
9 As a peer with lived experience, which means ones
10 who has recovered and successfully navigated the
11 mental health system. I can testify that one of
12 the problems with New York City mental health
13 system can be traced back to the many forced
14 hospitalizations that occur because of a police
15 response to those who are experiencing a mental
16 health crisis. That's why they don't have some
17 beds. I was forced hospitalized, taken out of my
18 home by police for no reason. I was not
19 experiencing a mental health crisis. I was
20 sitting on myself quietly when someone knocked on
21 my door and it was the police. A family member
22 had called 911 and told the operator that I had a
23 knife. Eight to nine police officers showed up
24 and an officer told me that I had to go with him.

25 No one asked me any questions or found

1 a knife near me, but I had to go with him. I was
2 afraid. So I put on my coat and shoes and
3 grabbed my medication because they told me to
4 bring it with me. The officer escorted me
5 downstairs and when I got outside, he asked me if
6 I wanted to go in the police car or the
7 ambulance. I chose the ambulance. Another
8 police officer said that he would ride with me.
9 They dropped me off at Bellevue Hospital, which
10 was a continuation of my nightmare.

11 I waited three hours before a doctor
12 saw me and when I told him that I needed my blood
13 pressure medication, he ignored me and told me to
14 go back to the waiting area. I didn't get my
15 blood pressure medication until two days later.
16 Unfortunately for me, it was a three-day weekend
17 and I was stuck in a place where I did not
18 belong. We were locked up like animals. People
19 were screaming, yelling, and banging on windows.
20 I was scared to death. I was also angry that a
21 family member lied about me, angry that I was
22 forced to go to the hospital, and angry when I
23 learned that I was stuck there until Tuesday.

24 When Tuesday finally came around, I was
25 taken upstairs to the ward and wasn't released

1 until two weeks later. I wish that the police
2 officer had at least asked me questions and
3 listened to my responses before telling me that I
4 had to go with him because I wasn't acting
5 violently in the slightest way. I also wish that
6 there was support systems available that included
7 appear someone like me with lived experience like
8 the one CCIT NYC proposes to prevent me from
9 being hospitalized in the first place. Correct
10 Crisis Intervention Today, New York City, is an
11 organization consisting of 80 plus mental health
12 organizations which initially favored all New
13 York City Police Department Police be trained in
14 crisis de-escalation, but after 18,000 police
15 officers were trained and millions of taxpayer
16 dollars were spent. People experiencing a mental
17 health crisis, still wound up dead when the
18 police intervened. Most of the deceased were
19 minorities.

20 CCIT NYC proposed mental health crisis
21 response system is modeled after the CAHOOTS
22 program in Oregon with a 35 plus year successful
23 track record. CCIT NYC is advocating for New
24 York City to contract with community-based
25 organizations to establish mental health crisis

1 response teams that consist of one counselor who
2 is appear has extensive training in de-escalation
3 and one AMT technician who is not an employee of
4 the New York City Bureau of the Medical Emergency
5 Services because they deal with the cops -
6 police, sorry.

7 The core characteristics of the CCIT
8 NYC proposals are non-police, non-coercive teams
9 that are default response to all mental health
10 and substance use crises. We need community-
11 based members and it should operate 24/7. The
12 response time we would like it to be comparable
13 to the response time of the -- and other
14 emergency matters. (Indiscernible) leadership
15 with peers, peers help a lot. Peers have gone
16 through this already. They know what it takes to
17 get forward, move forward, and they'll feel
18 better, you know, whatever wherever place they
19 would like to go. So, peers hired from effective
20 communities on every crisis response team and in
21 program leadership and on the oversight board.

22 Follow-up here connecting recipients to
23 voluntary services that includes housing and
24 support -- social support systems like they were
25 talking about today, crisis respites, and the

1 version centers. We need transparency and that
2 should be our evaluations to collect and analyze
3 data regarding long term outcomes including
4 housing availability, completion of treatment
5 programs, and the avoidance of future
6 hospitalizations.

7 Partnerships with community
8 organizations and mental health advocates already
9 working in space and uses 9-8-8 which will be
10 activated in New York by July 16, 2022 as a
11 calling number. In place of the police operated
12 911 system. A police response to a mental health
13 crisis can be deadly. In the last seven years in
14 New York, 19 individuals were shot and killed by
15 police responding to mental health crisis calls.
16 It's the 21st century and we need to look at the
17 proven and cost-effective alternatives to
18 psychiatric hospitalizations including mobile
19 crisis teams, crisis stabilization centers and
20 living rooms.

21 The goal is to help people in crisis
22 gain control of their symptoms while remaining in
23 their community. If we do not develop the
24 alternative response systems such as the one
25 proposed by CCIT NYC we will continue to see

1 theft, and abusive treatment of innocent people
2 experiencing a mental health crisis. Thank you.

3 LETITA JAMES: Thank you for your
4 testimony. You're right. Alternative response
5 systems obviously is a model that we should
6 support, provide resources, and the models are
7 out there. And so I thank you for your testimony
8 and I apologize that you had to experience that
9 unfortunate forced hospitalization. Thank you
10 ma'am.

11 ABISOLE FATADE: Last but not least,
12 (indiscernible). Please move the microphone
13 closer to you.

14 TAYA NEWITT: Hello, my name is Taya
15 Newitt. I suffer from PTSD and depression and my
16 mental health interaction -- I saw you on TV and
17 I -- when I saw this I contact you guys because I
18 tried to get help with resources and for my
19 treatment because I was -- I was approved and
20 established for PTSD and depression. And even
21 though I was approved and the judge approved it
22 and my doctor prescribed medications for me. The
23 carrier commits fraud.

24 The carrier for workers comp, they
25 commit a lot of fraud against mental health work

1 -- mental health injured workers. And I've been
2 trying to get help. I have wrote the governor.
3 I got no response -- actually, they transferred
4 me back to the (indiscernible) for the workers
5 comp that don't even answer my call. They -- I
6 spoke to them once in the last four years and my
7 attorney actually commit fraud, tell me to lie to
8 the judge in court outside court and I told the
9 judge, said this attorney right here next to me
10 tell me to lie to you that don't -- you told the
11 judge -- you told the carrier to get to
12 independent medical stuff and they only got one.

13 And so therefore, you know, it had
14 legal have legal consequence and they don't help
15 me. They don't help me. They -- I complain
16 every day. No one wrote me back. No one answer
17 me, I never complained to your office. Now, I
18 just understand that you are doing this. So, I'm
19 going to send you guys a bunch of all the old e-
20 mail.

21 I contact my congressman. He says that
22 he don't deal with federal he only deal with
23 state. But there's a lot of fraud with the
24 insurance carrier in workers comp. I told the
25 commissioner, I told the vice commissioner, I

1 told the office of general counsel, I have not
2 received not even an e-mail back from none of
3 those office and every day I'm going to keep
4 complaining until God come and they try
5 threatening me.

6 Joe from the office of general counsel
7 who's in charge of -- who's the head of the
8 ombudsman, he said Mr. Newitt, you know, they're
9 going to come after you. This is what he said to
10 me, you know, they're going to come after you,
11 they're going to get at you, you -- what you're
12 doing, they're going to come - I tell them and I
13 report it all the time and I wrote in a letter
14 said Joe told me that these people going to come
15 after me and they put in -- and in court they
16 even said, oh, we're going to muddy the water.

17 We -- that's what these people said in
18 their officer of the court. There's a lot of
19 fraud and I've been telling you guys and I'm
20 going to always say there's a lot of fraud with
21 work -- with injured workers getting help and
22 even when you gain approval and when -- even when
23 you gain approval they still don't help you.

24 They chop up my medication, my
25 medication was stopped then go -- even though it

1 was approved, the carrier paid then they don't
2 pay two months and then they -- then you have to
3 go to the judge and then the judge make them pay.
4 So, they do this intentionally. Even though they
5 know that they must -- it's already established
6 and they're supposed to pay.

7 Some of these medications I'm not even
8 supposed to stop without it -- the -- my
9 psychiatrist who I see once a month and my
10 psychologist who I see every week they tell me
11 these drugs you have to come off of it slow. So,
12 when they stop me from getting these drugs --
13 these medications instantly -- just suddenly it
14 bothers me because that -- these drugs and this
15 is what they do all the time.

16 And I complain. Today I had court
17 actually at 3 p.m. In that office back there and
18 I told them, you know, that -- the judge I order
19 -- I filed a report to get the audio and I heard
20 the judge and the carrier talking about my case
21 before I even came to the courtroom and they were
22 the only two in there and I wrote this up to the
23 office of general counsel. I wrote this up to
24 the judge supervisor. I have no response, no
25 response. And the one time they respond to me

1 they said mister, you were right but you had an
2 attorney.

3 Now I fired attorney when he told me to
4 lie to the judge. Attorney told me to lie to the
5 judge and I told the judge. Judge, this attorney
6 told me to lie to you. Nothing happened to the
7 judge. Yes. They gave me everything that was
8 supposed to give in to me.

9 But the action -- what if I listened to
10 the attorney? What if I had listened to --
11 because my common sense tell me, said no, if the
12 judge said to and you gave -- and you're telling
13 me, don't let the judge know that they did not do
14 it -- (indiscernible) independent medical report
15 on my psychologist. That don't make sense as you
16 as my attorney telling me that. And this is what
17 -- this is happened in court on record.

18 So, I have audio and the court minutes
19 of all these conversations and secondly the judge
20 is so disrespectful. A lot of times they told me
21 -- she actually told me shut up. The judge told
22 me shut up. I wrote up her supervisor, I wrote
23 up her and a supervisor wrote me back and said
24 she was wrong, on paper because she told me to
25 shut up.

1

2 I wrote the -- I wrote everybody every
3 time and they don't -- there's no response. And
4 that's why I'm here. When I saw that, you know,
5 my issue is that, yes, you know, we get -- there
6 is resources even when you're approved for
7 resources, you still don't get the treatment.
8 When you're black, there's a second-tier
9 treatment compared to when you're white.

10 Even the people who work for you, these
11 people, they treat us different. They don't
12 treat us the same when you call your office. I
13 spoke to the some of these congressmen and the
14 congressman is one way and the people who work
15 for him is another way. They and -- people see
16 this, I'm not going to lie and act like I don't
17 see it, I see it. These people -- so I
18 appreciate but there's a lot of fraud in workers
19 comp and there's a lot of fraud with the judge
20 and the carrier working hand in hand together and
21 I have been complaining and no one responds to
22 me, no one.

23 And they just they just keep giving me
24 what I want but they're not taking care of the
25 issue because it's not like I don't get what I'm

1 supposed to get, they make sure I get what I'm
2 supposed to get. You know, and you know they
3 passed new rules. The funny thing, they passed
4 new rules started May 2nd, my doctor who do the
5 neurologist, the head concussion neurologist
6 examination that the judge ordered them to do
7 every -- twice a week. She told me last week
8 that because the new rule came out, she cannot
9 longer be my doctor for that department.

10 So, I only have now just a psychologist
11 and a psychiatrist. But the neurologist, the
12 neuropsychologist who does that test, she doesn't
13 -- she says that she can't do it no more because
14 they're not paying her the same like how they
15 used to. So, now I never heard of this now in
16 the middle of treatment.

17 I (indiscernible) injured worker and I
18 have to go look for another neurologist and that
19 can cause a problem with my workers comp because
20 if there's not a doctor within the next six
21 months that come and put in some paperwork
22 regarding that, that the carrier could just say,
23 oh, that's like dead issue going underneath the
24 rug and this is how they use the process to
25 manipulate and target poor people.

1 And it's not, this is not the first
2 time I would say this. There's a lot of racism
3 with mental health, extremely racism in mental
4 health that I (indiscernible) Orlando you would
5 experience, that's what I'm telling you guys. I
6 experience a lot of racism with workers comp, the
7 -- and the carrier. Mostly the carrier and
8 sometimes your attorney like in my case, the
9 attorneys working against you.

10 As when my doctor told me these
11 decisions. Mr. Newitt is they make decisions on
12 the (indiscernible) not in the court and I find
13 that very disappointed and I refuse to live in
14 New York state. That requires me to be treated
15 that way. That's why I appreciate you and I
16 thank you are the people lawyer and I really
17 appreciate you for listening to me and it makes
18 me feel better. Thank you.

19 LETITA JAMES: Thank you, Mr. Newitt.
20 If you have any information, if you want to
21 submit to our office, we would appreciate it.
22 Thank you for being here and thank you for
23 testifying. I truly appreciate it. And I want
24 to also thank Ms. Graham-Nyaasi, did I say it
25 right? Thank you for your testimony and again I

1 apologize for your forced hospitalization, but I
2 really want to look at the Oregon model. And
3 thank you for your recommendations. And Mr.
4 Colavito, I look forward to seeing you in
5 Sullivan County and you telling me more about the
6 SALT program.

7 I thank you all. So, at the top of
8 this -- yes ma'am.

9 EVELYN GRAHAM-NYAASI: The CAHOOTS
10 model -

11 LETITA JAMES: Yes, ma'am.

12 EVELYN GRAHAM-NYAASI: -- they've been
13 in operation, last year they had 24,000 calls to
14 their center. Only 150 of those calls were
15 answered by the police. And they don't carry
16 weapons and no one has ever been killed or
17 injured.

18 LETITA JAMES: Thank you, we're going
19 to examine that model. I appreciate you all and
20 thank you for your testimony. And so this -- at
21 the top of this hearing, I said that instead of a
22 dark abyss, we need a supportive safety net of
23 care. We heard from 28 individuals in person
24 today and dozens more who sent in their testimony
25 from advocates, to providers, to New Yorkers

1 living with mental illness. They all painted a
2 clear picture of the state of health care in New
3 York. State of mental health care in New York
4 and how we can begin to have lasting
5 transformative change. There are a number of
6 individuals who submitted recommendations. We
7 will review them as well. We heard many
8 perspectives and issues that my office will
9 follow up in the coming weeks and months.

10 And again, we will have additional
11 hearings throughout the state. We heard from
12 Tony Carino, director of psychiatry and
13 (indiscernible) medical care NCUCS. He walked us
14 through intersectionality of mental care and
15 other health and social crisis like homelessness
16 and the criminal justice system.

17 We heard from Ron Richter, the CEO of
18 JCCA who said that a systemic refusal and
19 cumulative neglect by hospitals for psychiatric
20 care, especially for children. He's seeing that
21 over and over again and Council Member Lee who
22 identified the need for bilingual mental health
23 providers. And we've heard in great detail how
24 our children living with mental illness aren't
25 able to get the care they need with Alice Bufkin

1 saying that the children's system has been
2 starved.

3 We also heard from potential -- we also
4 heard about potential violations, federal
5 emergency medical treatment, and Labor Act or
6 EMTALA as well as violations of parity laws,
7 which requires anyone to be anyone coming to an
8 emergency department to be stabilized and treated
9 regardless of their insurance status or their
10 ability to care.

11 My office will be looking into this
12 issue and I encourage anyone who has been denied
13 treatment or feels like they were not treated
14 appropriately to contact my office by visiting
15 ag.dot.ny.gov, that's ag.ny.gov. The link to
16 submit your comments is on the web page on the
17 home page. And also there should be a telephone
18 number there as well, because I know individuals
19 do not have access to the internet.

20 A lot of what we heard today was
21 devastating, disturbing. My team is already
22 looking at possible areas of reform. We will
23 review each and every word of testimony and use
24 them to inform our issues moving forward because
25 this hearing was not simply about listening, it

1 was about listening in order to take action and
2 informing my office for future investigations
3 into allegations of inadequate mental health
4 treatment.

5 Individuals deserve answers and I will
6 do everything in my power to make sure that they
7 get them, but please understand that this is just
8 not a one off. We will continue to follow up.
9 We will continue to reach out and make sure that
10 individuals voices are heard and that individuals
11 understand that at this point in New York state
12 mental health care, we're at a crisis point and
13 we certainly need action.

14 I thank members of the team, I thank
15 the Office of Attorney General for doing an
16 absolutely fabulous job. And this concludes the
17 hearing and I thank you all for tuning in. Thank
18 you so much.

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C E R T I F I C A T I O N

I, Sonya Ledanski Hyde, certify that the
foregoing transcript is a true and accurate
record of the proceedings.

Sonya M. Ledanski Hyde

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Date: July 19, 2022

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