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# Written Testimony for NY Senate Bill S4547

## Chief Clinical Officer, Samaritan Daytop Village

Good morning. My name is Dr. Carolann Slattery, and I serve as Chief Clinical Officer at Samaritan Daytop Village, one of New York's largest and most comprehensive behavioral health organizations. For 65 years, Samaritan Daytop Village has provided evidence-based treatment and support services to thousands of New Yorkers struggling with substance use disorders, mental health conditions, and co-occurring disorders. We operate residential treatment programs, outpatient clinics, medication-assisted treatment services, and recovery support programs across New York State. I hold a doctorate in education and am a licensed clinical social worker. I strongly support Senate Bill 4547, the Treatment Not Jail Act.

Every day, I see the failures of our current approach. People with treatable conditions cycling through jails instead of receiving care. Treatment courts that exclude those who need help most. And a fundamental contradiction: we claim to offer treatment while using threats and incarceration to enforce compliance approaches that contradict everything we know about recovery.

Let me be clear about what the science tells us. Coerced treatment with punitive sanctions does not work as well as voluntary, harm reduction-based approaches. Recovery requires participant buy-in. Yet our current drug courts often mandate abstinence-only programs, prohibit evidence-based medications like buprenorphine or methadone, and jail people for relapse which is a normal part of the recovery process. This bill corrects these fundamental flaws.

Three key provisions deserve emphasis:

First, eliminating the guilty plea requirement for most charges protects people from collateral consequences that undermine recovery. I've watched clients successfully complete treatment only to lose housing, employment, or immigration status because of their plea. The criminal record becomes a permanent barrier to stability. Pre-plea diversion preserves due process while providing treatment access.

Second, the harm reduction framework is evidence-based. The bill allows medication for addiction treatment without court interference, recognizes that reducing use can be as valid as abstinence, and prohibits jailing people for clinical decisions. This aligns with American Society of Addiction Medicine standards and decades of research. When we meet people where they are, outcomes improve.

Third, expanded eligibility removes arbitrary barriers. Currently, most counties lack treatment courts entirely. Where they exist, people with serious mental illness, intellectual disabilities, or "the wrong charges that deemed them ineligible" are excluded even though these populations desperately need alternatives to incarceration. The bill's qualifying diagnosis framework is clinically sound: it includes serious mental disorders, neurodevelopmental conditions, and substance use disorders. It recognizes that trauma, psychosis, bipolar disorder, and cognitive impairments drive justice involvement and require treatment, not punishment.

The bill also includes critical clinical safeguards. Treatment plans must follow evidence-based practices from the Office of Mental Health and Office of Addiction Services and

Supports. Licensed mental health professionals,  not judges determine clinical appropriateness. Participants can seek second opinions. Privacy protections limit what courts can access. These provisions respect the therapeutic relationship and clinical expertise.

I want to address public safety directly. Research shows that diversion programs reduce recidivism more effectively than incarceration. Studies demonstrate that people charged with violent offenses do just as well in treatment as those charged with non-violent offenses. Most importantly, people stabilized in treatment are less likely to reoffend. This bill enhances public safety by addressing root causes rather than cycling people through jails.

The graduated response system replaces summary incarceration with clinically appropriate interventions. Courts must prove violations by clear and convincing evidence. Participants can present defenses. And crucially, the bill recognizes relapse as part of recovery, not grounds for automatic termination. This is how effective treatment works in community settings why should court-involved treatment be different?

From a provider perspective, current limitations prevent us from delivering optimal care. When courts restrict medications we prescribe, mandate treatment modalities that don't fit client needs, or require us to report information that breaches therapeutic trust, we cannot do our jobs effectively. This bill removes those barriers while maintaining appropriate accountability.

Finally, the access provisions are essential. Treatment must be available in the county where someone lives to maintain family connections, employment, and support systems. Telehealth options increase accessibility. Eliminating cost barriers ensures equity. The requirement that every county establish a diversion part addresses the current geographic lottery of justice.

Some will raise concerns about eliminating charge restrictions or allowing violent felonies. The evidence does not support these fears. What puts communities at risk is cycling people with untreated mental illness and addiction through jails. What enhances safety is connecting them to effective treatment and support.

I have witnessed the transformative power of genuine treatment. I have also witnessed the harm of coercive, punitive approaches disguised as help. This bill represents a paradigm shift from punishment to healing, from one-size-fits-all to individualized care, from abstinence-only to harm reduction, from guilty until proven recovered to innocent and deserving of help.

New York has an opportunity to lead the nation in creating a truly therapeutic alternative to incarceration. I urge you to pass Senate Bill 4547.

Thank you.

Dr. Carolann Slattery EdD, LCSW-R