Testimony before the NYS Legislative Mental Hygiene Fiscal Committee

Mental Hygiene Budget Hearing
February 5, 2021

Presented by
Harvey Rosenthal, Executive Director

New York Association of Psychiatric Rehabilitation Services

On Behalf of NYAPRS Members and
The NYAPRS Public Policy Committee
Chair: Carla Rabinowitz

NYAPRS Board of Directors
Co-Presidents: Marguerite Gayle, Tracie Plouffe

The New York Association of Psychiatric Rehabilitation Services represents a statewide partnership of thousands of New Yorkers who use and/or provide community mental health services and who are dedicated to improving services and social conditions for people with psychiatric disabilities by promoting their recovery, rehabilitation, rights and community integration
www.nyaprs.org

Good morning. Thank you to the chairs and members of the committees for this opportunity to once again submit to you the concerns of the thousands of New Yorkers represented by the New York Association of Psychiatric Rehabilitation Services.

NYAPRS is a very unique and nationally acclaimed partnership of New Yorkers with psychiatric disabilities and the community mental health professionals who support them in upwards of 85 community-based mental health agencies located in every corner of the state.

Under this big tent, recovering people consumers and providers have come together to form a powerful alliance that has worked successfully over the past 40 years to bring recovery values to the center of our system, protect and expand funding for community recovery focused services and our workforce, advance peer support and human rights and fight discrimination, expand access to housing, employment and transportation and help win landmark criminal justice reforms.

State mental health policy is a very personal matter for our NYAPRS community. Our members and many of our board members, our staff, and I all share a common journey of recovery which brings a unique passion and perspective to the concerns we bring before you today.

On behalf of thousands of NYAPRS members from across the state, I'd like to offer the following recommendations:

Restore 5% Cut to Community Behavioral Health Services

For far too long, community-based mental health agencies have struggled to keep up with ever growing needs for their services amidst ever-rising operating costs and stagnant funding. At the same time, they continue to contend with very high rates of staff turnover and vacancies due to salaries that are not competitive with the local Burger King.

But in the wake of COVID-19, a mental health pandemic is emerging that is expected to overwhelm the capacity of these programs, as the profound impact of social isolation and increased rates of depression, poverty, food insecurity, homelessness, suicide and overdoses are rising around us, most notably affecting low income individuals with disabilities.

The first line of response for New Yorkers with substantial needs of this kind has always been the array of flexible crisis, rehabilitation, advocacy, case management and peer support services that have funded with state and local aid. Yet, these services are precisely the ones that have been forced to deal with 20% withholds since July, resulting in staff layoffs and service reductions.

While the Administration has proposed to restore the withholds, recent statements are suggesting that that may not be possible.

And now, the Governor's budget proposes an across the board 5% cut for the same services. A cut of this kind will devastate services that are the last resort for thousands of vulnerable New Yorkers, many of whom are low-income individuals with disabilities and black, indigenous and people of color who were already facing significant barrier to access care due to systemic racism and discrimination.

As a result, these groups are twice as likely to given more severe diagnoses, hospitalized involuntarily, administered higher doses of antipsychotics against their will and overrepresented at every stage of our criminal justice systems.

Action: To avert program closures, access and reductions in service that have never been more needed, the State must immediately provide full funding for mental health services and restore withholds and the proposed 5% across the board cuts in the SFY 2021-22 Executive Budget.

Release $22 Million in Community Reinvestment Funding

Background: Over the past 25 years, the Community Mental Health Reinvestment program has played an essential role in New York's mental health system, creating and maintaining critically needed mobile intensive outreach teams, peer bridger and respite programs, crisis intervention, warm line and housing services for adults and children, family empowerment services, managed care transitional supports, forensic ACT team and rehabilitation services.

See details at https://www.omh.ny.gov/omhweb/transformation/.

Reinvestment funding represents of portion of the savings the state realizes when it closes a state hospital bed that has been vacant for over 3 months and that are valued at $110,000 per bed.

The 2021-22 Budget proposal includes a plan to not withstand authority to reinvest $22 million tied to the closure of an estimated 200 beds.

When state hospital beds are closed, community services of this kind are especially needed to promote recovery and relapse prevention and crisis support services that can replace the need for avoidable costly emergency room visits and hospital stays.

Reducing hospital capacity without increasing access to community services is very poor policy under any circumstances but reallocating desperately needed funding for essential supports at a time when they have never been needed more is unacceptable.

Action: NYAPRS urges the state Legislature to ensure that Reinvestment funding is used for its intended purpose, which is, to expand vital community service options, most notably for individuals who might otherwise would have been referred to a state hospital in their region.

Housing is Essential to Mental Health Recovery

There is no recovery without stable housing and consistent, reliable and accessible staffing and supports. In their absence, countless New Yorkers end up in avoidable cycles of relapses, repeat hospital readmissions, homelessness and incarceration.

However, while New York State has been a leader in creating housing for people with major mental health needs, it simply has never provided the levels of funding necessary to help housing agencies to keep pace with steadily increasing costs and demands.

As a result,

- Housing programs have experienced a steady erosion of 40 to 70% funding due to inflation since the mid-1980s and 1990s, resulting in a **combined deficit of $180 million**.
- Chronically low wages have made it extremely difficult to recruit and retain a qualified workforce to perform duties that are far more complex than they were 40 years ago.
- Housing providers are now declining to bid on new housing initiatives because the rates are simply too low, further reducing service capacity.

And now, far too many programs are at risk of closing at a time when they have never been needed more! The COVID-19 crisis has dramatically increased the demand for housing and basic supports due to steadily rising rates of homelessness, suicide and drug overdoses.

As a longtime member of the "Bring it Home, Better Funding for Better Care" campaign, NYAPRS has long been asking state leaders for increased financial support to help maintain New York's essential community-based mental health housing system.

Action: NYAPRS joins hundreds of agencies, advocates, families and faith-based groups who make up the Bring It Home! Campaign in urging policy makers to maintain* $20 million *in the FY 2021-22 Executive Budget.

'HALT' The Torture of Solitary Confinement!

Background: Imprisoned New Yorkers in solitary confinement spend twenty-three to twenty-four hours a day in space no bigger than an elevator, with no access to meaningful human interaction, for weeks, months, years, and even decades.

They are denied access to the commissary to purchase essential items like food to supplement the meager offerings they receive through a slot in their door. They are often denied visits which are critical to their well-being. Perhaps most senselessly, they are denied access to the kinds of programs that will address the underlying issues of any truly problematic behavior. They receive no educational or rehabilitative programming, and no transitional services to help them prepare for their return to society, increasing the rates of recidivism. In these conditions, people's minds and spirits crumble.

Many of these individuals have extensive mental health needs: a recent federal study found that "29% of prison inmates and 22% of jail inmates with current symptoms of serious psychological distress had spent time in restrictive housing in the past 12 months."
Despite the passage of SHU Exclusion Legislation in 2008 that seriously limited the number of individuals with major mental health conditions, there are currently almost **900 people on the OMH caseload in the box**, according to the Correctional Association of NYS. Further,

- at least one third of suicides in NY prisons took place in solitary confinement in 2019
- the rate of suicide attempts in solitary confinement was 12x higher than in the rest of the prisons in 2019

NYAPRS strongly urges state legislators to approve HUMANE ALTERNATIVES TO LONG-TERM (HALT) SOLITARY CONFINEMENT ACT 'HALT' legislation to:

- Prohibit solitary confinement for young and elderly people, people with intellectual, physical and mental disabilities, pregnant women and new mothers,
- End long term solitary confinement: place a limit of 15 consecutive days and a limit of 20 total days in a 60-day period on the amount of time any person can spend in segregated confinement.
- Create new Residential Rehabilitation Units as a more humane and effective alternative to provide segregated confinement and one that provides meaningful human contact and therapeutic, trauma-informed, and rehabilitative programs.
- Require training for Residential Rehabilitation Unit staff and hearing officers, public reporting on the use of segregation and oversight of the bill's implementation.

Fund Peer Crisis Counselor/EMT First Responder Police Alternatives!

Across the nation, community advocates, policymakers and mental health service leaders are working together to identity and implement new models to provide police alternatives to responses to people in acute emotional distress.

Police are not trained to be social workers or crisis counselors and an armed police officer responding to someone in crisis can be very triggering and escalate encounter rapidly and far too often with deadly results.

Furthermore, there is a structural lack of access to mental health resources for communities of color, which is further compounded by the much greater likelihood of a police officer to use deadly force on those communities. Hence the need for alternative first responder models are of critical importance when we seek justice for communities of color.

A growing body of experience is conclusively showing that sending mental health workers to be first on the scene can be done safely and effectively, as most mental health crises do not represent imminent threat to responders or anyone else.

One example is CAHOOTS, a 31-year old innovation that was developed in Eugene, Oregon that pairs a crisis de-escalator and an EMT who are dispatched by a 911 system or the police non-emergency number. Last year, out of a total of roughly 24,000 CAHOOTS calls, police backup was requested only 250 times and the team was able to respond to 17% of the Eugene Police Department's overall call volume.

NYAPRS is supporting an adaptation of the CAHOOTS that is under consideration in New York City that will consist of teams of peer crisis counselors and emergency medical technicians (EMTs). A person with lived experience can best relate to and respond to moments of crisis and an EMT worker can provide immediate medical assistance as many crisis calls involve accompanying physical health issues.

Action: Redirect $1 million from the Department of Corrections funding to fund peer crisis counselor/EMT pilots in one or more localities.

Oppose Expansion of Inpatient and Outpatient Commitment Standards
Redirect Funds to Boost Intensive Voluntary Outreach Initiatives
Support Crisis Stabilization Centers

Oppose Expansion of Inpatient Commitment Standards

Over the past 40 years, NYAPRS has been committed to the development of appropriate and effective strategies to engage and support 'at risk' individuals with the most serious challenges. In fact many of the individuals we have collectively engaged and supported would be on the streets, in the shelters, in prisons and jails and in almost endless cycles of relapse and hospital readmission had we not figured out how to build trust, know how to respond in a crisis and match services to what people say they need the most.

Throughout our history, NYAPRS has steadfastly opposed the use of coercion as a strategy to help people in distress and instead has identified numerous best practices strategies offer them assistance they may have previously resisted.

It's because we start where the person is, both in their lives and literally, be it on the streets or in the prisons.

We know how to employ harm reduction approaches that use less invasive trauma informed methods of making relationships that last…because so many of the people we're talking about here are victims of trauma and coercion only frightens, angers or drives people away from not towards help.

We know to use state of the art peer driven methods of providing immediate, intensive and sustain assistance to people, especially in a crisis.

And that help is not offered in a hospital but rather in a peer run respite or crisis stabilization program. New York can boast of having the internationally acclaimed and replicated programs of this kind right here in the upper Hudson Valley…but their model is based on choice rather than involuntary transport by a police officer.

We now know how to help the most troubled or challenged individuals…but all too often we don't because the services aren't sufficient or held to the highest account. But that's about system failure and its our responsibility to fix that system and provide alternative housing and services not cart off people to a psychiatric ward.

But that's not what we're talking about here.

1. Our response here to people's pain and fear, distress and vulnerability is to offer them policies of coercion, containment and control.
2. Our answer to people who are suffering and homeless is to take them involuntarily to a psychiatric ward. So many of these folks need emergency and other forms of housing. They want and need housing not a hospital.
3. Our response here is a one size fits all approach, whether it's a person with a mental illness, an addiction, a trauma survivor and anyone who has fallen on hard times and needs help not a psychiatric hospital that may rely on involuntary medication and sometimes seclusion and restraint.
4. This program relies on the response and judgement of police whom we have painfully learned again and again cannot be expected to know how to evaluate and engage an individual and who, too many times, escalate rather than deescalate the situation, sometimes ending in avoidable arrests, incarcerations or death.
5. The criteria are so broad. These criteria would apply to so many more people than has been considered. We're immediately talking about hundreds and, if

this definition becomes permanent, thousands of New Yorkers. And can we hospitalize thousands more over the coming years?

6. I believe we mean well here, and I hope that this is about providing assistance, not about sweeping the streets of people who worry or frighten us. This should be about compassion and compassion is not about coercion. We can do so much better.
7. And then there's the legal lens here. Disability rights lawyers are clear that the current danger-to-self standards for involuntary psychiatric hospitalization already apply here and that broadening the criteria and lowering rights protections is when someone is in immediate risk for harm from the life-threatening circumstances. But imposing coercion when someone is not currently at this level of risk but "likely" to be is unjust and unacceptable.
8. Finally, there's the issue of racial inequity. 2 out of 3 Forced outpatient orders are levied at people of color and we fear that this policy will follow the same path.

The answer to system failure isn't police transport to a psychiatric inpatient unit because someone thinks it may be likely that you may come to harm. Case law is clear: the standard is about immediate, clear and present risk of harm, not a prediction of it.

The answer to help the individuals we're talking about here are to be found in street outreach, in creating an innovative peer run drop-in center in and around the subways system.

Oppose Expansion of Kendra's Law Outpatient Commitment Orders

Kendra's Law outpatient commitment orders -–as written, the bill allows for an automatic extension of court ordered outpatient treatment without the involvement of the person subjected to the order and relieves physicians of their responsibility to appear in person at court proceedings that create involuntary treatment orders.
Involuntary Inpatient Commitment – the bill would increase authority for involuntary confinements in local hospitals according to broader, vaguely defined new standards.

For each of the last 20 years since the inception of Kendra's Law, the NYS Legislature has steadfastly opposed an expansion of this very controversial program that, in our view, is another example of the use of coercion and the courts to take the place of what our system is built on: our ability to successfully engage individuals in treatment that they choose to use in response to effective outreach, engagement and retention approaches.

The data tell us several things about the program:

- A 3-year study at Bellevue Hospital in 1999 compared the impact of providing an enhanced, better-coordinated package of services to 2 groups, one with and one without a court mandate. Results: "On all major outcome measures, no statistically

significant differences were found between the two groups', suggesting that people do better when they are offered more and better services voluntarily.
Yet, despite a NYS legislative directive to compare voluntary approaches and Kendra's Law court mandates, researchers failed to do so, conceding that they were only able to provide "a limited assessment of whether voluntary agreements are effective alternatives to initiating or continuing AOT" in their 2009 study
In fact, a later review of that study found that "the results do not support the expansion of coercion in psychiatric treatment."

- Current data culled this week again demonstrated racial inequity in the use of outpatient commitment orders: 2/3 of the order were for people of color tinyurl.com/19cufmnw.
  This consistent with racial inequities across our mental health and criminal justice systems. Today, BIPOC are more likely to be hospitalized involuntarily, administered higher doses of antipsychotics, administered medications against their will, given more severe diagnoses, and secluded and restrained. They are also more likely to be stopped by police, incarcerated, serve longer sentences and placed in solitary confinement than our white counterparts.

Voluntary Alternatives to Outpatient Commitment Orders

In 2019, the Assembly approved a $500,000 allocation to launch a new Project INSET model in Westchester County that has provided "immediate, intensive and sustained" response to individuals who would otherwise by placed on Kendra's Law court orders or were currently on one. The program has operated in Westchester and part of Rockland Counties and has an extraordinary record of engaging 80% of those individuals who had been considered unable to accept their need for treatment and support. See https://www.mhawestchester.org/news/mha-launches-inset.

It's clear that everyone looks to New York for the answer. And, in this case, New York can and must do better!

Crisis Stabilization Centers

NYAPRS is in strong support of the proposed expansion in crisis stabilization centers. Currently, there are six in operation in the state. One of the most prominent ones is the peer operated by international leader Steve Miccio and People-USA. See more at https://people-usa.org/program/crisis-stabilization-centers/.

Protect Adult Home Residents' Safety and Rights and Promote their Transition to the Community

The COVID-19 pandemic has had a devastating impact on residents of adult homes in New York State that has underscored the state's responsibility to ensure they are protected them from harm and from rights violations, while

ensuring that their voices are heard and their choices are respected. NYAPRS is advocating for the following actions.

Restore Funding for Essential Advocacy Programs

The pandemic has shown how vulnerable residents of adult homes are. At this critical moment, the governor's budget eliminates funding for resident organizing and advocacy.

Actions Needed:

- ***Restore $150,000 to maintain funding for the Coalition for Institutionalized, Aged and Disabled (CIAD)*** *is the leading voice for essential advocacy for adult home residents in New York City.*
- ***Restore the $170,000 to continue essential advocacy for residents*** *provided by the Adult Home Advocacy Program for Mobilization for Justice in New York City and Nassau-Suffolk Law Services on Long Island*
- ***Restore $60,000 for the Adult Home Resident Council Support Program*** *for Family Service League in Suffolk County.*

Strengthen Enforcement of Residents' Safety and Freedom from Abuse

Give the Department of Health, the agency responsible for the oversight of adult homes, tools it needs to enforce the regulations that keep residents safe and address systemic problems. Under the current enforcement system, scandalously poor conditions are chronic problems in some facilities, which avoid penalties by briefly correcting violations, only to fall out of compliance again.

Pass A.196 /S.1571 S.3460A to:

- ***Allow DOH to seek fines from facilities when residents are physically injured, financially abused, when their rights are violated by facility managers, or when violations are repeated within 12 months; and***
- ***Increase the maximum fine from $1,000 (set in 1977) to $2,000 per day per violation, and for repeat violations, $3,000.***

Extend Funding for New York's Self-Directed Care Program

Self-directed care is perhaps the most transformative mental health initiatives in the state and nation, providing the means to make critical improvements in the lives of program enrollees.

Self-Directed Care is about autonomy and choice. It's based on the idea that people are experts in their lives and should determine their own recovery

pathways. Participants work with peer service brokers to identify their personal goals and to make strategic purchases to achieve them.

In 2017, New York State launched two Mental Health Self-Directed Care (SDC) demonstration programs as part of a Medicaid demonstration waiver that is designed to help states test new approaches to service delivery Medicaid beneficiaries. The SDC pilot s have been operated by Community Access in New York City and Independent Living, Inc. in the Hudson Valley.

The pilots are helping to advance participants' recovery, wellness and community goals via the following purchases:

- employment: laptop and WIFI connection to search and apply for jobs
- education: tuition, schoolbooks, internet access for research
- transportation: Uber, MetroCard, small car repairs
- stable housing: security deposit, furniture, furnishing,
- improved self-care and health: dental work, acupuncture, nutritional aids
- increase their social connections and community participation: cell phone, minutes
- increased confidence and self-esteem.

Being voiceless in my own care perpetuated the idea that I was broken ... Self-direction is changing that."

State funding for the pilot will end in December 2021, despite original plans to make the program available statewide as a benefit of the Medicaid Managed Care 'Health and Recovery' initiative in 2022.

Action: We respectfully request that NYS approve the necessary funding of $980,000 to continue this project for the remaining two quarters of our contracts, consistent with our agreements (January 1, 2022 through June 30, 2022), and to support the expansion of the program for others to achieve their self-defined recovery goals.

Revise New York's Olmstead Most Integrated Setting Plan: Prioritize Community Alternatives to Nursing Homes and Employment Outcomes for People w Disabilities

Approximately 40% of COVID-related deaths nationally have involved individuals in congregate care facilities, most notably in nursing homes, psychiatric hospitals, assisted living facilities and adult and group homes. While these facilities have far too often represented a dead end for millions, they have now become deadly incubators for the virus, making it tragically clear why New Yorkers must be supported to lives in their community of choice rather than being confined to living in an institution.

Despite all our efforts to advance community inclusion and integration, far too many individuals languish in these institutions but for the lack of community-based housing and employment related supports.

Employment and economic self-sufficiency are fundamental to successful community integration. Yet, while the national employment rate was 77.8%. employment rates for working-age people with disabilities in America was 37%, 15% for people with psychiatric disabilities and 29% for African Americans.

The Supreme Court's Olmstead decision made states legally responsible and liable for helping people with disabilities to live and work in the most independent settings. New York has an appointed body to oversee state policy in this regard, the Most Integrated Setting Coordinating Council, that is comprised of representatives from public agencies and 9 members of the disability community, 6 of whom are selected by the Senate and Assembly.

The MISCC has committed itself to updating the state's 2013 Olmstead Plan to greatly accelerate the provision of community alternatives to nursing home placements and considerably higher rates of employment.

Action: The Legislature should play a stronger role in ensuring that New York's Olmstead Plan identifies high measurable targets and aggressive strategies to advance the independence of our citizens with disabilities.

Pass Legislation Requiring New York to Address the Devasting Consequences of Unresolved Trauma

The impact of trauma on behavioral health has become increasingly apparent in recent years with studies suggesting that over 90% of people with psychiatric diagnoses identify themselves as survivors of trauma.

Unresolved trauma as a result of Adverse Childhood Experiences (ACEs) can negatively impact development across the life span and intergenerationally; contributing to substance misuse, child abuse, poverty, and incarceration.

Failure to address the consequences of unresolved trauma can negatively impact an individual's ability to form healthy adult relationships and pursue activities essential to his or her wellbeing.

Survivors' attempts to cope with unresolved trauma may be misinterpreted by others as "non-compliance" and result in punitive service delivery responses that contribute to a revolving door of poor and inappropriate treatment, service refusal, costly repeat hospitalization, homelessness, and incarceration.

Increasingly, national efforts have attempted to change the narrative around trauma from one of negative outcomes based on past experiences to an opportunity to create positive outcomes through prevention, treatment, and outreach programs that are based on effective trauma-informed approaches, shifting the focus from illness to wellness--to hope, recovery, and resilience.

Executive Orders have been passed in Oklahoma, Oregon, Utah, Wisconsin and Delaware requiring state agencies to create trauma-responsive communities, organizations, and schools.

In 2018, Congressional bi-partisan support for the importance of trauma-informed care was recognized through the passage of U.S. HR 443/SR 346, 2018- a resolution recognizes the importance, effectiveness, and need for trauma-informed care among existing programs and agencies at the Federal level and declaring May 22, 2018 as ‘‘National Trauma-Informed Awareness Day’’.

Actions:

- ***Pass A03074/S01067 amends the State Constitution to declare that the prevention and mitigation of adverse childhood experiences (ACEs) is a matter of public concern and require that ACES are addressed by the state and its subdivisions.***
- ***Ask your representative to support cross-sector collaborations and community-based training and education throughout New York State to ensure a coordinated effort to address the devastating impact of trauma.***

CONCLUSION

Throughout the past 4 decades, NYAPRS has enjoyed a close and collaborative relationship with our friends in the state legislature, who have a long tradition of initiating or approving groundbreaking new initiatives and landmark legislation on behalf of our community. We look forward to another productive year together.

Thank you for this opportunity to share our community’s concerns, hopes and recommendations.