



**Testimony before the NYS Legislative
Mental Hygiene Fiscal Committee**

**Mental Hygiene Budget Hearing
February 14, 2022**

Presented by
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New York Association of Psychiatric Rehabilitation Services

On Behalf of the NYAPRS Board of Directors and Community

NYAPRS serves as a state and national change agent dedicated to improving services, public policies and social conditions for people with mental health, substance use and trauma-related challenges, by promoting health, wellness, rights and recovery, with full community inclusion, so that all may achieve maximum potential in communities of choice.

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Good morning. Great thanks 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.

My name is Harvey Rosenthal and I have served as NYAPRS CEO over the past 30 years.

Since 1981, NYAPRS has represented a partnership of tens of thousands of New Yorkers with psychiatric disabilities and the community service providers who support them in 85 agencies across the state. Our aim has always been to improve services, public policies and social conditions for people with mental health, substance use and trauma-related challenges, by promoting their health, wellness, rights and recovery and full community inclusion.

Our commitment is very personal: I am in long term mental health recovery as are most of our Board and staff and many leaders who head up many of our member agencies.

I will make very brief references and recommendations about the Executive Budget but will primarily address the mental health crisis we face today in New York City and in other urban centers across our state.

NYAPRS gives great thanks to Governor Hochul and her Administration for putting forward the best single best budget I've seen in those 30 years. Great thanks are also due to Commissioner Sullivan and her OMH team as well.

Given the little time I have, the recommendations below touch upon many of our most important priorities, including funding for community agencies, criminal justice reforms, rights protections and support for adult home residents, re-procurement of Medicaid managed care plans, funding for veterans' peer support services and the creation of a Mental Health Maternal Workgroup. See below:

Funding For Community Based Behavioral Health Services

- Approve 5.4% COLA and amend language to include Health Home Care Management and Supportive Housing programs and remove the "sunset" revision to help ensure that COLAs will be included in all future budgets
- Workforce retention bonuses
- Include a \$500 million Investment in Behavioral Health Services
- Approve \$104 million to bolster housing programs over the next two years
- Approve \$111 million in Managed Care Reinvestment for Behavioral Health Services

Criminal Justice Reforms

- Pass Clean Slate (S1553A/A6399)
- Pass Treatment not Jails (S2881B/A8524A)

Adult Home Residents

- Protect Adult Home Residents' Safety and Rights and Promote their Successful Transitions to the Community (A.196/S.1576)

- Add \$250,000 for Adult Home Residents' Advocacy

Create a Maternal Mental Health Workgroup (S.7752/A.9085)
Support the re-procurement of Medicaid Managed Care Plans
Joseph A. Dwyer veteran peer support initiative \$7.5 million

But, I want to focus on the mental health crisis that has reached a boiling point in New York City.

New York's mental health community is horrified by the tragic murder of Michelle Go. We abhor such violence, especially since people with mental illness are [11 times more likely than the general population to be the victims of violent crime](#).

In reaching for solutions, we must not make matters worse. Vilifying people with serious mental illnesses as violent individuals who should be swept off of the streets and [forced to accept treatments](#) that have failed them in the past will do more harm than good.

Flawed studies purport to show that Kendra's Law outpatient commitment orders are responsible for improvements in the lives of people living with serious mental illness, but the truth is that they [fail to make a scientific comparison](#), head to head, between involuntary and alternative voluntary models as required by this Legislature when the bill was approved in 1999. This, in the face of the facts that, according to OMH's website last Thursday, 20,127 voluntary agreements to receive enhanced service package were recorded in comparison to 19,547 outpatient commitment orders.¹ An earlier 'Bellevue Study' that did so found that more and better discharge plans and follow up made the difference, not the court orders.

It is important to note here that the primary author of that study, Dr. Marvin Swartz, wrote that, "people who understand what outpatient commitment is would never say this is a violence prevention strategy²."

It is particularly outrageous that Kendra's Law has been levied against people of color³ — a reactive approach in lieu of more engaging preventative and culturally competent care. Since the program's start in 1999, Kendra's Law-authorized court orders have involved Black and Hispanic people in New York City, further criminalizing mental illness and disincentivizing people from seeking out community-based supports that could have made a difference before a crisis ever occurs.

We should adamantly reject forced treatment and involuntary confinement in favor of proven strategies of outreach and engagement that promote long-term recovery and respect people's rights and dignity.

¹ <https://tinyurl.com/2p83m88s>

² <https://www.hmpgloballearningnetwork.com/site/behavioral/article/aot-cost-effectiveness-study-stirs-national-debate>

³ <https://tinyurl.com/2p83m88s>

A number of real answers can be found in the smart and strong initiatives that Mayor Adams and Gov. Hochul are swiftly rolling out over the next few months. These initiatives include:

- a team of 20 clinicians and case managers that will provide immediate and expanded assistance to connect New Yorkers experiencing homelessness to critical services;
- the establishment of [20 “Safe Options Support” teams](#) to engage and speed referrals to area treatment and support services, as developed in collaboration with city government;
- a [replacement of 911 with a new 988 specialized mental health emergency hotline](#) that will be able to refer people to follow-up mental health and addiction recovery services, including new peer-led crisis stabilization and respite centers that will provide “urgent care” mental health, substance use and medical services.

Voluntary alternatives to court orders work. We need many more of them, including teams of peer counselors and EMTs in place of police first responders, as proposed by Correct Crisis Intervention Today. We have evidence of other successful models right here in New York. The [Project INSET](#) voluntary peer-led model that is currently funded by the state Assembly in Westchester County has [successfully engaged 80%](#) of a cohort of individuals who qualify for and would otherwise get a Kendra’s Law court order. Let’s expand this model throughout the state.

New York City has recently implemented a number of successful, voluntary alternatives. We need more of them. One such program is [Behavioral Health Emergency Assistance Response Division teams](#) of EMTs/paramedics and mental health professionals who are providing an effective alternative to police first responders. Another is [Intensive Mobile Treatment teams](#) that provide continuous support to clients who have had frequent contact with the mental health, criminal legal, and homeless services systems and haven’t been able to get their needs met by these traditional treatment models.

We also badly need more Clubhouse capacity to permit members from [Fountain House](#) and related programs to conduct outreach and enrollment at soup kitchens, pantries, shelters, justice-related settings and hospitals, Times Square, parks, trains and subway stations

We want to extend our great thanks to Mayor Adams for seeking more funding for critical needed services from state government last week and for previous comments that get to heart of one the essential question: with all of these good services on the street now and in the coming weeks and months: where is the accountability? who’s in charge of following up and coordinating care for each New Yorker in need of appropriate and adequate services and supports?

We are very encouraged by Mayor Adams’ [appointment](#) of former Fountain House CEO Dr. Ashwin Vasan to serve as commissioner of the New York City Department of Health and Mental Hygiene. As a long time expert in our field, he fully understands these issues — and the right way to help people in acute psychological distress.

Any effort to seriously address homelessness and promote stability must also include housing and clinical supports. New York State [allocated \\$125 million](#) in housing and case management services back in 1999 to address the needs of this population. The state must direct newly proposed funding to [expand Housing First](#) and other harm reduction initiatives that have successfully engaged untreated and addicted New Yorkers into stable housing and services.

But let's be clear: Expanding involuntary approaches will not address this crisis. We know how to voluntarily engage people with serious mental illness, especially approaches that feature pivotal roles for peer staff.

We must address provide true remedies that address scandalously brief hospital stays with poor discharge plans with insufficient housing and grossly inadequate follow up services.

We must recognize people's right to receive the best care available without defacing them and denying them their rights. New Yorkers with and without mental illnesses have a right to feel safe...and there's a lot we are finally doing and will do to make that happen.

Community Voluntary Long-Term Innovations for At-Risk Individuals

Residential

- 1. Crisis Respite – Intensive Crisis Residential Program:** OMH program: "a safe place for the stabilization of psychiatric symptoms and a range of services from support to treatment services for children and adults. are intended to be located in the community and provide a home-like setting."
<https://omh.ny.gov/omhweb/bho/docs/crisis-residence-program-guidance.pdf>.
- 2. Crisis Respite (shorter term and less intensive):** OMH Program: "Crisis Respite Centers provide an alternative to hospitalization for people experiencing emotional crises. They are warm, safe and supportive home-like places to rest and recover when more support is needed than can be provided at home. The Crisis Respite Centers offer stays for up to one week and provide an open-door setting where people can continue their daily activities. Trained peers and non-peers work with individuals to help them successfully overcome emotional crises."
<https://www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-respite-centers.page>.
- 3. Peer Crisis Respite programs:** OMH funded; Peer operated short-term crisis respites that are home-like alternatives to hospital psychiatric ERs and inpatient units. Guests can stay up to seven nights, and they can come-and-go for appointments, jobs, and other essential needs. Offers a "full, customizable menu of services designed to help them understand what happened that caused their crisis, educate them about skills and resources that can help in times of emotional distress, explore the relationship between their current situation and their overall well-being, resolve the issues that brought them to the house, learn simple and effective ways to feel better, connect with other useful services and supports in

the community, and feel comfortable returning home after their stay.”
<https://people-usa.org/program/rose-houses/>.

4. **Housing First:** a housing approach that prioritizes permanent housing for people experiencing homelessness and frequently serious mental illness and substance use issues. Supportive services including substance use counseling and treatment are part of the model, but abstinence or even engagement in services is not required. <https://endhomelessness.org/resource/housing-first/>.
5. **Soteria:** a Therapeutic Community Residence for the prevention of hospitalization for individuals experiencing a distressing extreme state, commonly referred to as psychosis. We believe that psychosis can be a temporary experience that one works through rather than a chronic mental illness that needs to be managed. We practice the approach of “being with” – this is a process of actively staying present with people and learning about their experiences.
<https://www.pathwaysvermont.org/what-we-do/our-programs/soteria-house/>.
6. **Safe Haven:** provides transitional housing for vulnerable street homeless individuals, primarily women. “low-threshold” resources: they have fewer requirements, making them attractive to those who are resistant to emergency shelter. Safe Havens offer intensive case management, along with mental health and substance abuse assistance, with the ultimate goal of moving each client into permanent housing. <https://breakingground.org/our-housing/midwood>.
7. **Living Room model:** a community crisis center that offers people experiencing a mental health crisis an alternative to hospitalization. health crises a calm and safe environment. The community outpatient centers are open 24 hours a day, 7 days a week and people receive care immediately. Services include: crisis intervention, a safe place in which to rest and relax, support from peer counselors; intervention from professional counselors including teaching de-escalation skills and developing safety plans, Linkage with referrals for emergency housing, healthcare, food and mental health services. https://smiadviser.org/knowledge_post/what-is-the-living-room-model-for-people-experiencing-a-mental-health-crisis.
8. **Crisis Stabilization Centers:** 24/7 community crisis response hub where people of all ages can connect immediately with an integrated team of clinical counselors, peer specialists, and behavioral health professionals, as well as to our local community’s health & human service providers, to address any mental health, addiction, or social determinant of health needs. People use the Stabilization Center when they’re experiencing emotional distress, acute psychiatric symptoms, addiction challenges, intoxication, family issues, and other life stressors.
<https://people-usa.org/program/crisis-stabilization-center/>.
9. **Parachute NYC / Open Dialogue:** provides a non-threatening environment where people who are coming undone can take a break from their turbulent lives and think through their problems before they reach a crisis point. Many who shun hospitals and crisis stabilization units will voluntarily seek help at respite centers. Parachute NYC includes mobile treatment units and phone counseling in addition to the four brick-and-mortar respite centers. <https://www.nyaprs.org/e-news-bulletins/2015/parachute-nyc-highlights-success-of-peer-crisis-model-impact-of-community-access>.

Non-residential

1. **"Safe Options Support" teams:** consisting of direct outreach workers as well as clinicians to help more New Yorkers come off of streets and into shelters and/or housing. SOS CTI Teams will be comprised of licensed clinicians, care managers, peers and registered nurses. Services will be provided for up to 12 months, pre- and post-housing placement, with an intensive initial outreach and engagement period that includes multiple visits per week, each for several hours. Participants will learn self-management skills and master activities of daily living on the road to self-efficacy and recovery. The teams outreach will facilitate connection to treatment and support services. The SOS CTI Teams will follow the CTI model – a time-limited, evidence-based service that helps vulnerable individuals during periods of transitions. The teams will be serving individuals as they transition from street homelessness to housing.
https://omh.ny.gov/omhweb/rfp/2022/sos/sos_cti_rfp.pdf.
2. **INSET:** a model of integrated peer and professional services provides rapid, intensive, flexible and sustained interventions to help individuals who have experienced frequent periods of acute states of distress, frequent emergency room visits, hospitalizations and criminal justice involvement and for whom prior programs of care and support have been ineffective. MHA has found that participants, previously labeled "non-adherent," "resistant to treatment" or "in need of a higher level of care" and "mandated services," become voluntarily engaged and motivated to work toward recovery once offered peer connection, hope and opportunities to collaborate, share in decisions and exercise more control over their lives and their services and supports. their treatment plans. Engaged 80% of people either AOT eligible or AOT involved.
<https://www.mhwestchester.org/our-services/treatment-support/intensive-and-sustained-engagement-and-treatment>.
3. **NYAPRS Peer Bridger™ program:** a peer-run and staffed model providing transitional support for people being discharged from state and local hospitals, with the goal of helping people to live successfully in the community, breaking cycles of frequent relapses and readmissions. The program include inpatient and community based intensive one on one peer support groups, discharge planning, connection to community resources; provides access to emergency housing, wrap around dollars and free cell phones and minutes. <https://www.nyaprs.org/peer-bridger>.
4. **NYCDOHMH Intensive Mobile Treatment teams:** provide intensive and continuous support and treatment to individuals right in their communities, where and when they need it. Clients have had recent and frequent contact with the mental health, criminal justice, and homeless services systems, recent behavior that is unsafe and escalating, and who were poorly served by traditional treatment models. IMT teams include mental health, substance use, and peer specialists who provide support and treatment including medication, and facilitate connections to housing and additional supportive services.
<https://mentalhealth.cityofnewyork.us/program/intensive-mobile-treatment-imt>.
5. **Pathway Home™:** a community-based care transition/management intervention offering intensive, mobile, time-limited services to individuals transitioning from an institutional setting back to the community. CBC acts as a single point of referral to multidisciplinary teams at ten care management agencies (CMAs) in CBC's

broader IPA network. These teams maintain small caseloads and offer flexible interventions where frequency, duration and intensity is tailored to match the individual's community needs and have the capacity to respond rapidly to crisis. <https://cbcare.org/innovative-programs/pathway-home/>.

6. **Forensic Peer Support:** The Westchester Forensic Mobile Team works directly with law enforcement in the field and courts seeking alternatives to incarceration (ATI), to provide immediate crisis response and/or transitional care services to people at risk of entering the criminal justice system due to under-addressed mental health, addiction, or social determinant of health issues.⁴
7. **Fountain House:** We also badly need more Clubhouse capacity to permit members from Fountain House and related programs to conduct outreach and enrollment at soup kitchens, pantries, shelters, justice-related settings and hospitals, Times Square, parks, train and subway stations.⁵
8. **Assertive Community Teams:** ACT Teams are an evidenced-based practice that offer treatment, rehabilitation, and support services, using a person-centered, recovery-based approach, to individuals that have been diagnosed with serious mental illness (SMI). Services are provided to individuals by a mobile, multi-disciplinary team in community settings. Individual referrals for ACT services may be made by the individual, on his or her own behalf, a family member, mental health agency or hospital, mental health service provider, police and court system.⁶
9. **NYC Mobile Crisis Teams:** A Mobile Crisis Team is a group of behavioral health professionals — such as social workers, peer specialists and family peer advocates — who can provide care and short-term management for people who are experiencing severe behavioral crisis. Services are primarily provided in people's homes, as well as in schools for children experiencing crisis. Mobile Crisis Teams are available in all five boroughs.⁷

These remedies present real solutions. We must not give in to proposals that erode significant due process protections, that are inconsistent with existing provisions of NYS mental hygiene law and that will result in certain litigation, creates equal protection issues, and would likely deprive people of existing constitutionally protected liberty interests.

Thank you once again for the opportunity to make this presentation. I hope and believe that public policy in New York will not be determined by fear over facts, inflammatory coverage and unfounded and unjust characterizations of New Yorkers who deserve compassionate, consistent and sustained help rather than a rush to lock up the violent mentally ill'. Our \$4 billion public mental health system must and do so much better.....right now and in the coming months....to overcome a long history of failure to engage and provide sustained support to some of our most vulnerable New Yorker. They, their families and the public deserve no less.

⁴ <https://people-usa.org/program/forensic-mobile-team/>

⁵ <https://www.fountainhouse.org/>

⁶ <https://omh.ny.gov/omhweb/act/>

⁷ <https://www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-mobile-crisis-teams.page>

Going forward, we must favor a planning process that engages the people who are closest to the issue, establishes clear measurable goals, and uses data to track the effectiveness of the chosen interventions. A truly inclusive process would engage service users, family members, providers, elected officials and subject matter experts to define the core problems to be solved and use their feedback on a continuous basis as policy ideas are developed and refined.

**Oppose Expansion of Kendra's Law:
Fund Additional Voluntary Outreach, Engagement and Housing Programs**

- a. Allocate \$35 million to create 750 more **Housing First** supportive housing programs and implement this model in existing housing, given the current 10% vacancy rate.
- b. Allocate \$2 million to create 4 **INSET peer outreach and engagement programs**
- c. Allocate \$3 million to Create 6 **Transitional Peer Bridger Programs** for improved hospital discharge planning and follow up
- d. Fund **teams of Mental Health/EMT First Responders** (Police Alternatives)
- e. Approve **9-8-8 Mental Health Hot Line** Funding and anticipate creating a cell phone tax to sustain the program.
- f. Fund **additional Crisis Stabilization Centers**