NYLPI

JUSTICE THROUGH COMMUNITY POWER

Testimony of

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on behalf of

New York Lawyers for the Public

Interest

before

The Joint Legislative Budget

Hearing on Mental Hygiene

February 14, 2022

Thank you for the opportunity to present testimony today regarding the mental health provisions of the Governor's budget bill.

Since New York Lawyers for the Public Interest (NYLPI) was established over 40 years ago, we have prioritized advocating on behalf of individuals with mental health conditions, and we have consistently fought to ensure that the rights of individuals with mental health conditions are protected by every provision of New York's Mental Hygiene Law and in every aspect of New York's service delivery system. Core to our work is the principle of self-determination for all individuals with disabilities, along with

the right to access a robust healthcare system that is available on a voluntary, non-coercive basis.

We have long been on record opposing Mental Hygiene Law Section 9.60 -- "Kendra's Law" -- as insufficiently safeguarding the rights of persons with mental health concerns and failing to offer appropriate health services -- and we continue to oppose these provisions. We are, however, gravely concerned about the Budget Bill's proposed amendments to Kendra's Law, which would present even greater harms to the disability community.

Quite simply, there is no place for coercion. Forced "treatment" is not treatment at all, and it has long been rejected by health practitioners -- to say nothing of the disability community – in favor of numerous best practices strategies that offer assistance even to those who have previously resisted offers of care[1]. There are multiple less invasive models of care[2] that New York must invest in to avoid the tragedy and enormous cost of forced treatment. At the heart of these models are the trained peers –individuals who have lived mental health experience -- that makes them ideally suited to implement effective harm reduction and de-escalation techniques, especially during crises. To quote my colleague Harvey Rosenthal, the executive director of the New York Association of Psychiatric Rehabilitation Services (NYAPRS) who is also testifying today, "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 it's our responsibility to fix that system and provide alternative housing and services, not cart off people to a psychiatric ward."

Any proposal to ease the ability to force people into in-patient or out-patient "treatment" must be seen in the context of whom we're entrusting to "remove" these individuals. As we now surely know all too well, the police, who are steeped in law and order, are not at all well-suited to deal with individuals with mental health concerns. New York's grim statistics of its police killing 19 individuals who were experiencing mental health crises, and seriously injuring countless others, in the last six years alone, is sad testament to that.

Forced "treatment" must also be seen in the context of the ensuing racial disparities. Of the 19 individuals killed at the hands of New York police, 16 were people of color. This systemic racism also underlies the disproportionate prevalence of disability in the Black community and other communities of color[3]. Likewise, racism is at the heart of the similarly vast disparities of forced treatment, which will only worsen if the current protections are removed from the Mental Hygiene Law and more discretion is left in the

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[1] *See, e.g.*, de Bruijjn-Wezeman, Reina "Ending Coercion in Mental Health: The Need for a Human Rights-Based Approach," Committee on Social Affairs, Health and Sustainable Development, Council of Europe, Parliamentary Assembly, Doc. 14895 (May 22, 2019), https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=27701&lang=en.

[2] *See* the attached list of long-term, voluntary programs that have excellent track records.

[3] Mayor's Office for People with Disabilities, "Accessible NYC" (2016), https://www1.nyc.gov/assets/mopd/downloads/pdf/accessiblenyc_2016.pdf.

hands of the police. And critical to Kendra's Law, the racial disparities of its application are vast. In New York City, since 1999, 77% of Kendra's Law orders are implemented against Black and Brown individuals[4].

While there is extensive literature supporting voluntary treatment, there is no support for the success of forced outpatient treatment generally, or Kendra's Law in particular. The studies which suggest that Kendra's Law has resulted in improved circumstances for those with mental disabilities, did not undertake the necessary comparison between voluntary and involuntary treatment, and Assisted Outpatient Treatment ("AOT") certainly has never been proven to be a violence prevention strategy[5].

The proposed amendments to Kendra's Law will further deny people with mental health concerns appropriate treatment, greatly reduce their rights to self-determination, and not result in violence prevention. It is wholly inappropriate to expand Kendra's Law (Section (c)(4)(iii)) to permit an AOT order to be issued where an individual has had a prior order in place in the prior six months and merely meets a vague "standard" of having experienced a "substantial increase in symptoms of mental illness" with absolutely no need to show the individual has engaged in any acts of violent behavior or threats of such behavior. Violent behavior is at the heart of Kendra's Law and is the very least of what must be shown to authorize its implementation. Failure to limit forced treatment to such circumstances clearly violates constitutional due process mandates and disability non-discrimination laws.

While NYLPI does not object to authorizing the Kendra's Law examining physician to appear by video conference at the hearing (Section(h)(2)) during a pandemic or something

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[4] *See https://my.omh.ny.gov/analytics/saw.dll?Dashboard&PortalPath=%2Fshared%2FAOT%2F_portal%2FAOT%20Assisted%20Outpatient%20Treatment%20Reports&Page=Characteristics%20-%20Demographic%20Characteristic&Action=Navigate&col1=%22AOT%20Characteristic%22.%22Characteristic%22&valsql1=%22SELECT%20%5C%22AOT%20Characteristic%5C%22.%5C%22Characteristic%5C%22%20FROM%20%5C%22AOT%5C%22%20%20where%20%5C%22AOT%20Characteristic%5C%22.%5C%22Characteristic%5C%22%20%3D%20%27%40%7Bcharacteristic%7D%7BRace%2FEthnicity%7D%27%22&psa1=%22AOT%22&col2=%22AOT%20Characteristic%22.%22Characteristic%22&valsql2=%22SELECT%20%5C%22AOT%20Characteristic%5C%22.%5C%22Characteristic%5C%22%20FROM%20%5C%22AOT%5C%22%20%20where%20%5C%22AOT%20Characteristic%5C%22.%5C%22Characteristic%5C%22%20%3D%20%27%40%7Bcharacteristic%7D%7BRace%2FEthnicity%7D%27%22&psa2=%22AOT%22&col3=%22AOT%20Characteristic%22.%22Region%22&val3=%22New%20York%20City%22&psa3=%22AOT%22&col4=%22AOT%20Characteristic%20Age%22.%22Region%22&val4=%22New%20York%20City%22&psa4=%22AOT%22&var5=dashboard.variables%5B%27characteristic%27%5D&val5=%22Race%2FEthnicity%22&psa5=%22AOT%22&var6=dashboard.currentPage.variables%5B%27region%27%5D&cov6=%22AOT%20Characteristic%22.%22Region%22&val6=%22New%20York%20City%22&psa6=%22AOT%22&var7=dashboard.currentPage.variables%5B%27region_age%27%5D&cov7=%22AOT%20Characteristic%20Age%22.%22Region%22&val7=%22New%20York%20City%22&psa7=%22AOT%22.*

[5] *See* https://www.hmpgloballearningnetwork.com/site/behavioral/article/aot-cost-effectiveness-study-stirs-national-debate.

of a similarly dangerous nature, physicians must not be allowed to simply testify remotely for convenience's sake or the like. An individual subjected to AOT is entitled to the due process right to confront the individual who seeks force treatment – in person.

NYLPI objects to the proposed amendment which would allow otherwise confidential medical and legal records to be shared, without consent, with directors of community services or other service providers (Section (s)) as being violative of HIPAA and all relevant privacy laws.

Thank you for your consideration. I can be reached at (917) 804-8209 or RLowenkron@NYLPI.org, to further discuss my testimony and to ensure that ALL New Yorkers are properly served.

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About New York Lawyers for the Public Interest

For over 40 years, New York Lawyers for the Public Interest (NYLPI) has been a leading civil rights advocate for New Yorkers marginalized by race, poverty, disability, and immigration status. Through our community lawyering model, we bridge the gap between traditional civil legal services and civil rights, building strength and capacity for both individual solutions and long-term impact. Our work integrates the power of individual representation, impact litigation, and comprehensive organizing and policy campaigns. Guided by the priorities of our communities, we strive to achieve equality of opportunity and self-determination for people with disabilities, create equal access to health care, ensure immigrant opportunity, strengthen local nonprofits, and secure environmental justice for low-income communities of color.

NYLPI's Disability Justice Program works to advance the civil rights of New Yorkers with disabilities. NYLPI disability advocates have represented thousands of individuals and won campaigns improving the lives of hundreds of thousands of New Yorkers. Our landmark victories include integration into the community for people with mental illness, access to medical care and government services, and increased accessibility of New York City's public hospitals. We prioritize the reform of New York's response to individuals experiencing mental health crises, and are engaged in multiple policy, education, and litigation efforts to that end.

Community Voluntary Long-Term
Innovations for At-Risk Individuals
February 8, 2022

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. **Family Crisis Respite:** trained and paid community members with extra space in their homes provide respite for individuals who can thereby avoid hospitalization.
8. **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.
9. **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/.

10. **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.mhawestchester.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. **NYCDOMHM 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/.