BEFORE THE NEW YORK STATE SENATE FINANCE
AND WAYS AND MEANS COMMITTEES

JOINT LEGISLATIVE HEARING

In the Matter of the
2024-2025 EXECUTIVE BUDGET ON
MENTAL HYGIENE

Hearing Room B
Legislative Office Building
Albany, New York

February 13, 2024
9:34 a.m.

PRESIDING:

Senator Samra G. Brouk
Chair, Senate Committee on Mental Health

Assemblywoman Helene E. Weinstein
Chair, Assembly Ways & Means Committee

PRESENT:

Senator Thomas F. O'Mara
Senate Finance Committee (RM)

Assemblyman Edward P. Ra
Assembly Ways & Means Committee (RM)

Assemblywoman Aileen Gunther
Chair, Assembly Committee on Mental Health

Senator John W. Mannion
Chair, Senate Committee on Disabilities

2024-2025 Executive Budget
Mental Hygiene
2-13-24

PRESENT: (Continued)

Assemblywoman Rebecca A. Seawright
Chair, Assembly Committee on People with Disabilities

Senator Nathalia Fernandez
Chair, Senate Committee on Alcoholism and Substance Use Disorders

Assemblyman Phil Steck
Chair, Assembly Committee on Alcoholism and Drug Abuse

Assemblyman Angelo Santabarbara

Assemblywoman Mary Beth Walsh

Assemblyman Khaleel M. Anderson

Senator Michelle Hinchey

Assemblywoman Anna R. Kelles

Assemblyman Chris Eachus

Assemblyman Alex Bores

Senator Gustavo Rivera

Assemblywoman Jo Anne Simon

Assemblyman Brian Maher

Senator Lea Webb

Assemblywoman Taylor Darling

Assemblyman Jake Blumencranz

Senator John C. Liu

Assemblywoman Jodi Giglio

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PRESENT: (Continued)

Assemblyman Harvey Epstein

Senator Patricia Canzoneri-Fitzpatrick

Assemblyman Chris Burdick

Senator Peter Oberacker

Assemblyman Jarett Gandolfo

Assemblywoman Karen McMahon

Assemblyman Keith P. Brown

Senator Jacob Ashby

Assemblyman Edward C. Braunstein

Assemblywoman Emily Gallagher

Assemblyman Sam Berger

Senator Rob Rolison

Assemblywoman Monique Chandler-Waterman

Assemblyman Philip A. Palmesano

Senator Julia Salazar

Assemblyman Manny De Los Santos

Senator Bill Weber

Assemblyman Michael J. Norris

Senator Jessica Scarcella-Spanton

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SENATOR BROUK: Good morning, everyone. I am not Senator Liz Krueger, but sitting in today for our dear Finance chair -- Senator Samra Brouk, chair of the New York State Senate Committee on Mental Health, and cochair of today's budget hearing.

Today is the 11th of 13 hearings conducted by the joint fiscal committees of the Legislature regarding the Governor's proposed budget for the state fiscal year '24-'25. These hearings are conducted pursuant to the New York State Constitution and Legislative Law.

Today the Senate Finance Committee and the Assembly Ways and Means Committee will hear testimony concerning the Governor's proposed budget for the following agencies: the Office of Mental Health, the Office for People With Developmental Disabilities, the Office of Addiction Services and Supports, and the Justice Center for the Protection of People With Special Needs.

Following each testimony there will be

some time for questions from the chairs of the fiscal committees and other legislators.

I'll now introduce members of the Senate. Today we have with us the chair of our Disabilities Committee, Senator Mannion. We are joined by Senator Webb and we are joined by Senator Rivera. I think I got everybody.

I will now hand it over to Assemblymember Helene Weinstein, chair of the Assembly Ways and Means Committee, to introduce her members.

CHAIRWOMAN WEINSTEIN: Thank you, Senator.

So we have with us Assemblywoman Gunther, chair of our Mental Health Committee; Assemblyman Steck, chair of our Alcoholism Committee; and Assemblywoman Seawright, chair of our Disabilities Committee.

We're also joined by Members Bores, Braunstein, Burdick, Eachus, and Simon. And Mr. Epstein.

So Mr. Ra will be here shortly. And I

will introduce the members of the Minority in a few moments.

Back to you, Senator.

SENATOR BROUK: Thank you, Assemblymember.

I also want to say Senator Fernandez, our Alcoholism chair, has also joined us.

And now I will hand it over to Senator Tom O'Mara, ranking member of the Senate Finance Committee, to introduce members from his conference.

SENATOR O'MARA: Thank you, Chairwoman.

Good morning, all.

On our side, we have Ranking Member Senator Peter Oberacker and Senator Rob Rolison.

Thank you.

SENATOR BROUK: Wonderful.

Representing each of the agencies, I would like to welcome Dr. Ann Marie Sullivan, commissioner, New York State Office of Mental Health -- good morning -- Dr. Chinazo Cunningham, commissioner, New York State

Office of Addiction Services and Supports; and Kerri Neifeld, commissioner, New York State Office for People with Developmental Disabilities.

After the final question-and-answer period, there will be an opportunity for members of the public to briefly express their views on the proposed budgets under discussion.

At this time I would like to begin with Panel A: Dr. Sullivan, Dr. Cunningham, and Commissioner Neifeld.

Dr. Sullivan?

CHAIRWOMAN WEINSTEIN: Just before you go, I just want -- we should just review the time frame for everyone.

But first I did want to just introduce the members of the Minority who are here from the Assembly, if that's okay. The ranker on Mental Health, Member Gandolfo; the Alcoholism ranker, Keith Brown; the Disabilities ranker, Jodi Giglio. And Mr. Blumencranz and Mr. Maher.

And just as a reminder, this panel

gets 10 minutes for each member to speak. The chairs of the relevant committees will have 10 minutes after the panel is finished to ask questions of the panel. And we'll review the rules once we get to the nongovernmental witnesses.

And we just always encourage everybody, the commissioners as well as the members of the public who will be speaking later, don't read your testimony. It's been distributed, it's posted. Please use your three minutes to tell us what's important.

Thank you, Senator.

SENATOR BROUK: Go ahead, Commissioner. Thank you.

OMH COMMISSIONER SULLIVAN: Good morning. I'm Dr. Ann Sullivan, commissioner of the New York State Office of Mental Health. Chairs Krueger, Weinstein, Brouk and Gunther and members of the respective committees, I want to thank you for the invitation to address Governor Hochul's fiscal year 2025 proposed budget.

I'm pleased to report that this budget

substantially builds on Governor Hochul's $1 billion plan to develop a truly comprehensive mental health system.

We began this transformation last year, building services to address the post-pandemic needs of our youth, widely expanding access to community services, and expanding intensive treatment and supports for the most seriously mentally ill. Our staff traveled across the state, engaging communities, to inform our efforts to implement these newly funded initiatives. All funds will be released by the end of March.

The work was approached with a particular emphasis on diversity, integrated care, and the importance of peers in delivering services.

As part of last year's plan, OMH added 150 new state-operated inpatient beds and partnered with community hospitals to restore nearly 500 beds taken offline during the COVID pandemic. This year's budget will build on this success by opening an

additional 200 state hospital beds, with a focus on specializing them for individuals with the most complex needs, and including additional Transition to Home units for our chronically unsheltered clients.

The expansion will also provide capacity for youth with complex needs and individuals with recurring criminal justice involvement, and also an increased forensic bed capacity.

Expanding inpatient capacity, however, is only effective if it results in individuals being successfully transitioned back to the community. The budget fosters connections between hospitals and community providers, with a focus on communication, planning, and data systems to improve patient outcomes after they leave an inpatient or ER setting. OMH will convene subregional working meetings to ensure that these connection efforts are focused on the unique needs of each community.

Governor Hochul's continued commitment to improving mental health also focuses on

addressing three key areas: placing the spotlight on youth mental health, barriers to care by insurance coverage, and the needs for individuals with serious mental illness who are not effectively engaged in treatment.

In March 2023, Governor Hochul launched a Youth Mental Health Listening Tour to hear directly from middle and high school students about their experiences with mental health. OMH partnered with the Office of Children and Family Services to conduct additional listening sessions. The Governor listened when youth said they needed more services in their schools, a voice in developing those services, and when family wanted more access to treatment and more control over their child's access to social media.

Given this input, Governor Hochul has proposed establishing a Youth Advisory Board to ensure that the voice of youth continues to inform all our work. She also pledged to provide startup funding for any school wanting a school-based mental health clinic

and has promised enhanced reimbursement rates, while also ensuring these services are adequately reimbursed by insurance carriers.

The budget proposes legislation to control addictive algorithms aimed at youth and increase parental controls over social media access. In addition, the proposed budget will add state-operated psychiatric inpatient beds to serve children and adolescents with specialized needs.

This year's budget includes $20 million in new resources that will:

Add 12 new Youth Assertive Community Treatment teams that will serve more than 1,000 youth;

Provide a 25-percent increase to Medicaid rates for partial hospitalization programs;

Expand youth-led peer programs, including Teen Mental Health First Aid training and safe spaces using peer ambassadors to engage teens;

And expand specialized Children's Community Residences focused on youth

transitioning into adulthood.

Maternal mental health initiatives will also be funded with $1.6 million in new resources to ensure that service providers engaging pregnant and postpartum New Yorkers are equipped to provide the very best care. Specialized training will be developed for 988 Suicide & Crisis Lifeline providers.

Training for Project TEACH Maternal Mental Health will also be expanded and offered to an array of frontline practitioners.

Additionally, the Office of Mental Health has been selected by SAMHSA to participate in a National Learning Collaborative on this maternal health.

One of the many tenets of the mental health system is to engage individuals in treatment that supports recovery and helps them to live successfully in the community. This also helps to reduce the need for hospitalization and involvement in the criminal justice system.

OMH will work intensively with

hospitals and emergency rooms to implement new regulations for best practices in admission and discharge planning, including a requirement that ensures individuals are not discharged without an appropriate plan and access to follow-up services.

In addition, for arrested or incarcerated individuals not effectively engaged in treatment, this year's budget includes $24 million to fund criminal justice and community mental health forensic initiatives, including a dedicated OMH team to work with regional field offices focused on connections to services; mental health navigators to work in county courts with the courts, mental health coordination teams and local providers, and referring individuals to treatment and services; 100 new transitional housing beds for individuals with mental illness leaving the criminal justice system; 10 new Forensic ACT teams; a specialized supportive housing program to help individuals and staff support the needs for those who have unfortunately experienced

repeated arrests and difficulty engaging in mental health treatment; and an expansion of CIT training.

Ensuring access to care. All insurers must pay adequately for behavioral health services. To ensure proper access, commercial insurers will have to pay at least the Medicaid rate for OMH-licensed clinic services.

In addition, recently posted regulations by the State Department of Financial Services will require a 10-day access to behavioral health appointments, accurate provider directories, and easy access to out-of-network services whenever in-network services are unavailable.

Finally, the mental health workforce is a vital component of any expansion and improvement plan. As we continue to implement and expand recruitment and retention strategies -- including the Mental Health Loan Repayment Program, which this year reserves an additional $4 million investment for child-serving practitioners

specifically -- this year's budget also includes a 1.5 percent cost of living increase, additional funding for job marketing, a job bank, a behavioral health fellowship program, and a focus on rural investments.

Again, thank you for the opportunity to testify on the Executive Budget, and I am happy to answer any questions you may have.

OASAS COMMISSIONER CUNNINGHAM: Good morning, Senator Brouk, Assemblymember Weinstein, Senator Fernandez, Assemblymember Steck, and distinguished members of the Legislature. My name is Dr. Chinazo Cunningham, and I'm the commissioner of the New York State Office of Addiction Services and Supports.

Thank you for the opportunity to present Governor Hochul's fiscal year '25 Executive Budget and how it supports our work at OASAS on behalf of those impacted by substance use disorder and problem gambling.

First, however, I want to update you on some accomplishments in the past year.

New York has made Opioid Settlement funds available to localities and community-based organizations faster than any other state in the nation. The fiscal year '23 Enacted Budget allocated $192 million in settlement funds, and OASAS has made all those funds available.

Of the $212 million from fiscal year '24, $144 million in Opioid Settlement funds have already been made available to support prevention, treatment, harm reduction, and recovery services across the state. We have plans to make the remaining funding available in the coming months.

Initiatives have been identified in alignment with the Opioid Settlement Fund Advisory Board's recommendations, within 10 key priority areas. That includes establishing integrated outpatient and opioid treatment programs, which will significantly expand access to methadone treatment; additional initiatives to expand access to medication treatment, including low-threshold buprenorphine; scholarships to support the

workforce; youth prevention programs; support for recovery centers and transportation; enhanced outreach and engagement; and more.

In addition, last year OASAS launched an online ordering portal, making lifesaving harm reduction supplies available to the public, free of charge. Over the past 18 months, more than 70,000 naloxone kits, 5 million fentanyl test strips and 4 million xylazine test strips were shipped to individuals and organizations across the state. This effort joined a major statewide media campaign designed to raise awareness about addiction, describe addiction services available, and reduce stigma associated with addiction.

July also saw the opening of the first Mobile Medication Unit in New York State. These mobile units bring a wide array of addiction services and medical care directly to underserved communities. New Yorkers can expect additional units to roll out across the state this year.

The fiscal year '25 Executive Budget

will allow OASAS to continue these critical initiatives and enhance support of our provider system and the individuals they serve. Specifically, this year's budget includes more than $46 million in Opioid Settlement funds to support priority areas identified by the advisory board and targets over $17 million for local municipalities, which is in addition to the $110 million provided to localities in the last two years.

In all, the proposed OASAS budget contains roughly $1.2 billion, including $170 million for State Operations, $898 million for Aid to Localities, and $92 million for Capital projects. It continues the Opioid Stewardship funds, which allows OASAS to expand harm reduction services and provide financial assistance to help ensure individuals can access treatment and medication.

Workforce recruitment and retention remains a top priority across the OASAS system of care. Despite the ongoing

challenges, recent historic investments into the addiction workforce helps us support and expand a skilled, compassionate network of professionals. The Executive Budget includes additional support through a 1.5 percent cost-of-living adjustment, representing three straight years of COLA increases, totaling $76 million in the OASAS budget.

This action builds upon the $23 million in Opioid Settlement funds supporting workforce initiatives, including a newly announced Leadership Institute and paid internship programs.

In treating individuals with co-occurring substance use and mental health conditions, close collaboration is a priority for OASAS and the Office of Mental Health. The budget supports ongoing efforts to triple the number of Certified Community Behavioral Health Centers to better address individuals' complex needs, regardless of their ability to pay.

OASAS and OMH will also continue the rollout of Crisis Stabilization Centers,

which provide support, assistance, and urgent access to care to those who desperately need it.

Since 2022, state law requires medication treatment for all substance use disorders in carceral settings. I am very proud to report that all 44 prisons and all 58 jails are implementing all forms of medication treatment for substance use disorders. The proposed budget provides funding for OASAS to expand its support for county correctional facilities to maintain and enhance their treatment programs.

State revenues from casinos and mobile sports betting will enable OASAS to continue prevention efforts related to public awareness campaigns promoting responsible gambling. OASAS is also developing guidance for the State Department of Education to help educate young people about the potential risks of underage gambling. Further, we established a new Problem Gambling Bureau within OASAS to develop enhanced training for clinicians, improve problem gambling

screening, and collect important data that monitors gambling behaviors among adults and youth.

Regarding the legalization of adult use cannabis, OASAS is raising awareness for its responsible use through a brand-new social media campaign and the development of a toolkit containing information about the effects of cannabis on youth. In addition, we're collecting important data from youth and young adults about their cannabis behaviors and attitudes, while also training providers on evidence-based prevention of, and treatment for, cannabis use disorders.

The OASAS continuum of care includes programming and supports to help individuals achieve and maintain their personal health and recovery goals. In the fiscal year '25 Executive Budget the Governor builds on the investment made last year in Recovery Community Centers with $12 million from Opioid Settlement funds, and adds an additional $5 million to continue services that were established with federal funding

that will end this year.

Lastly, the proposed budget includes ongoing support for a five-year capital plan to ensure the health and safety of individuals and proper maintenance of facilities.

As outlined today, the proposed Executive Budget will allow OASAS to continue its person-centered, harm-reduction, data-driven, equitable approach to service delivery that meets people where they are and ultimately saves more lives. OASAS will continue ensuring that New Yorkers have a full continuum of prevention, treatment, harm reduction, and recovery programming and services.

We appreciate your ongoing support of these critical efforts, and I look forward to working with you to better serve those in need. With that, I welcome any questions.

Thank you.

OPWDD COMMISSIONER NEIFELD: Good morning, Chairs Brouk and Weinstein, Disability Committee Chairs Mannion and

Seawright, and other distinguished members of the Legislature. I am Kerri Neifeld, commissioner of the New York State Office for People With Developmental Disabilities.

Thank you for the opportunity to provide testimony about Governor Hochul's fiscal year 2025 Executive Budget proposal and how it benefits New Yorkers with developmental disabilities.

I want to start by acknowledging and thanking both the Governor and the Legislature for their support of people with developmental disabilities and our service system. The last two budgets have included historic investments in the OPWDD system and demonstrated the state's commitment to the nearly 135,000 people who access our services. Your acknowledgement and commitment to people with developmental disabilities helps us to amplify their voices and improve their services.

OPWDD recently released updates to our Strategic Plan. The five-year plan represents a continued effort to be

responsive to people's needs and to envision the future of our service system together with our stakeholders.

The three overarching goals outlined in our Strategic Plan include strengthening our agency's infrastructure, transforming the system through innovation and change, and enhancing person-centered supports and services. As part of the first goal, strengthening our workforce continues to be our highest and most urgent priority.

Staffing levels of direct support professionals continue to be of great concern. And for the third consecutive year, the Governor's Executive Budget provides funds to support our providers in addressing this crisis. The proposed budget includes a 1.5 percent cost-of-living adjustment, which would build on the previous two years' budgets, for a cumulative increase of nearly $1 billion to OPWDD provider agencies. Additionally, over the last few years, significant investments have been made in the state's direct support workforce as well.

The proposed budget also supports recalculating provider reimbursement rates, known as rate rebasing. Rate rebasing is a federally required process where we update provider reimbursement to reflect changes in the actual cost of delivering services. The full annual gross value of rebasing will be $350 million and, when combined with the new resources associated with the proposed 1.5 percent COLA, will provide an increase of more than $480 million for the provider network once fully implemented. These investments in our system will help service providers to maintain critical supports.

Additionally, OPWDD has made tremendous strides toward professionalizing and publicly elevating the direct support workforce through our partnerships with the National Alliance for Direct Support Professionals and SUNY. These collaborations create a career ladder for DSPs through national certifications, while also providing opportunities to gain college credits.

As highlighted recently on PBS

NewsHour, DSPs participating in the credentialing program have reported increased morale and improved outcomes for the people they support. I am happy to report that to date, over 1,000 DSPs have been certified in New York.

OPWDD has programmed over $60 million in current-year resources to continue support for these programs in the years ahead, and will also be making them available for the first time to the state's direct support workforce. Working with the New York Alliance for Inclusion and Innovation, we are identifying best practices on recruitment and retention as a resource for service providers.

In the coming weeks, OPWDD will launch a $30 million statewide DSP recruitment campaign to assist provider agencies with finding new staff. We know that there is no single solution to the current workforce crisis, and we will continue to pursue every opportunity to strengthen our direct care workforce.

The proposed budget also supports our goal to transform the system through innovation and change. It includes legislation that would allow people with developmental disabilities and their families, once approved by a nurse, to train their support staff to administer medication and perform other simple tasks. This will benefit many people who strive for greater independence.

Additionally, the proposed budget calls for the Most Integrated Settings Coordinating Council to update New York's Olmstead Plan, which will facilitate increased person-centeredness, choice and inclusion. This work will lead to more people with disabilities learning, working, and enjoying their lives within their communities.

The Executive Budget proposal further supports our goal of system transformation by investing in new service opportunities. It devotes $60 million in new state resources which, when matched by the federal

government, can total up to $120 million. This investment helps to expand the services our sector provides.

The Governor's proposed budget continues the annual $15 million investment in community-based supportive housing. This funding builds on the $125 million in capital resources that have been invested since 2015 to develop independent housing opportunities for people with developmental disabilities.

The Executive Budget proposal also aligns with our agency's second strategic goal to transform our system through innovation and change by including a $6.7 million investment to fund the Governor's commitment to becoming an Employment First state. OPWDD, in partnership with the Chief Disability Officer, will lead this multi-agency effort to increase employment opportunities for people with disabilities.

This investment builds on last year's commitment to make New York a model employer and to encourage New York businesses to

employ people with disabilities. Backed by legislation sponsored by Senator Mannion and Assemblymember Burdick and signed into law by the Governor, OPWDD has trained 14 businesses on the benefits of hiring people with developmental disabilities, and we are looking at ways to further expand the training's reach.

The Governor's proposed budget also includes a $1 million increase to Special Olympics NY, to support their work with inclusive sports training, skill building and competition, and to provide health screenings and health education.

In alignment with the third goal of our strategic plan, to improve services and supports by making sure they are person-centered, OPWDD has prioritized strengthening diversity, equity, and inclusion within our service system.

We have expanded our stakeholder engagement to include those who have been historically underserved by OPWDD, and we are working closely with community-based

organizations and providers who have expertise in serving diverse these communities, to ensure our understanding of their needs.

In addition, we are entering the second year of a three-year project with Georgetown University's National Center for Cultural Competence to improve our cultural and linguistic capacity and our system's ability to serve New Yorkers with developmental disabilities.

Finally, I am happy to report that with your support, particularly that of Senator Mannion and Assemblywoman Woerner, OPWDD kicked off the "Look Beyond My Developmental Disability" anti-stigma campaign this past year. This campaign was created by people with developmental disabilities and the people who support them, and the positive feedback we have received has been tremendous.

This year, as we enact a new state budget, I am hopeful that we will be able to continue pursuing and achieving our goals for

improving how New York supports people with developmental disabilities -- through a strong workforce, system innovation, and improved supports and services.

I look forward to working with all of you as we advance these goals and strive to create a more inclusive and accessible New York for people with developmental disabilities.

Thank you.

SENATOR BROUK: Thank you, Commissioners.

We will start with our questions now. As a reminder, chairs of relevant committees have 10 minutes for question and answer; ranking members will have five minutes; and every other legislator will have three minutes.

With that, we will start with our chair, Senator Fernandez.

SENATOR FERNANDEZ: Good morning. Thank you so much, Commissioners, for being here.

I have a few questions, so I'm just

going to try to get through it. There might be jumping around.

But starting with the work of OASAS, combined with Mental Health, what is being done about co-occurring disorders? I know there is dual licensing that has started that's out there. Could you describe what is the work to address that?

OASAS COMMISSIONER CUNNINGHAM: Absolutely.

So we recognize that it's very important that we can fully address people with co-occurring disorders. We know that people with addiction often have mental health conditions as well.

So just to start off with, as you mentioned, we have over 200 programs that have integrated licenses, both with OMH and OASAS, along with the Department of Health. And they have the authority to function as a single program, and we are continuing to improve on that and expand that.

SENATOR FERNANDEZ: What difficulties have you found, or any barriers with that

dual licensing right now?

OASAS COMMISSIONER CUNNINGHAM: I'm sorry?

SENATOR FERNANDEZ: Any difficulties or barriers that you've seen?

OASAS COMMISSIONER CUNNINGHAM: I mean, we've certainly gotten feedback from programs that there's -- you know, it's still not as seamless as they would have expected. And so we are working closely with the Office of Mental Health to sort of revise that and to come up with a, you know, a sort of new system that allows our whole system to really have different levels of integrated care.

So that's something that we're working on right now to really improve that existing integrated license.

In addition, you know, there are many initiatives that we are working on together. We are tripling CCBHCs across the state, which allow people with co-occurring disorders or either mental health or substance use disorders, to have really wraparound comprehensive services.

In addition, we have Crisis Stabilization Centers that are also occurring in every region. So for immediate access to care, they're available 24 hours a day, seven days a week, to address mental health or substance use crises.

We're also doing a lot of training with the workforce as well, so cross-training between both systems. And we're offering scholarships at OASAS, and that includes scholarships to individuals who are staffed in OMH programs or DOH programs so they can get the addiction training.

And our procurement process has also changed as well. And so part of the scoring for procurement includes how programs are going to address mental health or substance use, depending on whether --

SENATOR FERNANDEZ: For our youth, how do they address mental health and substance use disorder? We're seeing a growing number of our youth experiencing substance use disorders and co-occurring disorders. So what is the plan or the action plan being

done from your offices to address our youth that are suffering?

OASAS COMMISSIONER CUNNINGHAM: We're also working very closely with the Office of Mental Health, especially as they're expanding their school-based services. So we are including addiction prevention in that work. And then with our prevention programmers, we're also enhancing our mental health training. So for example, screening for suicidality is now incorporated into a lot of our programming.

So, you know, specifically for the youth in schools, we are collaborating there.

SENATOR FERNANDEZ: In the -- oh, go ahead.

OMH COMMISSIONER SULLIVAN: I would just like to add, too, that the 988 crisis system is extensively training people to be able to do integrated care. Anybody calling into 988 -- adults, youth, anyone.

And all the new services that OMH is putting up in terms of housing, all of these services are open to individuals with dual

diagnosis. And we're doing some specialty training for people to be able to deal with that.

So really the connections between the services we're developing is very, very tight. So basically all the new services will have integrated care.

SENATOR FERNANDEZ: Thank you.

Switching to another topic, the Governor has proposed scheduling in a number of new compounds -- not just fentanyl, but stimulants, hallucinogens, depressants, including xylazine, psilocybin and ibogaine.

How would the scheduling allow you to do your work? Or how would the scheduling of all these compounds impact your ability to do your work?

OASAS COMMISSIONER CUNNINGHAM: Yes, so certainly we know that there, you know, is an increase in the number of adulterating substances that are entering the illegal drug market. And we recognize that it is important to be able to detect them, to inform the community about them, and then to

give the community tools, you know, to be able to change their behavior depending on what they're finding in the market.

I mean, for that reason, Senator Fernandez, you know, we've made fentanyl test strips and xylazine test strips available easily on our website, and we've already shipped out over 5 million fentanyl test strips and 4 million xylazine test strips.

In addition, you know, in terms of the scheduling, I mean, our agency does not have the authority to schedule. But I think that for us really the focus is on making sure that people are aware of what's in the drug supply and then giving them the tools so that they can change their behavior accordingly and remain safe.

SENATOR FERNANDEZ: What research is your office doing on any alternative medicines and practices?

OASAS COMMISSIONER CUNNINGHAM: So, you know, we certainly understand the importance of research and data. I mean, I'm

a researcher -- you know, have been doing research for over 20 years before becoming a the commissioner of OASAS. So using a data-driven approach is absolutely one of the guiding principles at OASAS.

SENATOR FERNANDEZ: Well, some of these compounds that she wants to schedule might -- well, actually, would it impede work being done to conduct research on alternative treatments such as psilocybin and ibogaine?

OASAS COMMISSIONER CUNNINGHAM: Really our focus has been on the existing FDA-approved medications because we know that they are extremely effective. They reduce death by 50 percent. And there's not many other things that we do in healthcare that reduce death by 50 percent.

So our focus has really been on taking what we know from decades of research and making sure that people have access to that.

SENATOR FERNANDEZ: So you don't do any original research on your own.

OASAS COMMISSIONER CUNNINGHAM: We do original research. We also have a research

RFP that is currently out right now, using Opioid Settlement funds to expand our research.

But really our focus is on improving access to tried-and-true effective treatment.

SENATOR FERNANDEZ: Okay. Many advocates have declared this summer -- they did it this summer -- that we are in a state of emergency when it comes to our opioid crisis and what is being done about it. Do you agree that we have reached a state of emergency? And if the Governor did declare it, what would that allow you to do to help individuals seek treatment?

OASAS COMMISSIONER CUNNINGHAM: We absolutely recognize the urgency of the overdose epidemic.

SENATOR FERNANDEZ: But do you think we're in a state of emergency?

OASAS COMMISSIONER CUNNINGHAM: We certainly are acting with urgency. We know that this is the worst that an overdose epidemic has ever been on record.

You know, and for that reason we've

really worked hard to focus on harm reduction, to make sure that people can stay alive. So, you know, using naloxone, fentanyl test strips, xylazine test strips, and -- and going out and reaching those who are at highest risk.

SENATOR FERNANDEZ: Well, more to that state of emergency is the other areas besides what you just said. And it was touched upon earlier with aid to transportation and housing. Those are components of someone's recovery, making sure that there is stability in their life.

Could you speak about the transportation support that was mentioned? I think the -- forget which one of you mentioned it.

OASAS COMMISSIONER CUNNINGHAM: Absolutely. So there are many transportation initiatives that we have funded over the years. We recognize how important transportation is, particularly in rural communities, both for treatment and for recovery.

So we are continuing that. That is one of the 10 priority areas of the Opioid Settlement Fund Advisory Board, which we agree with. So we are continue our ongoing support of transportation initiatives across the state.

SENATOR FERNANDEZ: It is my impression that we need to do a little more in assisting with transportation aid.

But for housing, there's barriers that continue to remain in someone finding a stable home after going through treatment. Can you speak on that? Is there anything that you're aware of?

OASAS COMMISSIONER CUNNINGHAM: Absolutely. So we have a full continuum of services at OASAS that range from, you know, crises -- so like withdrawal management all the way through supportive housing, and everything in between.

So we have recently invested more money in transitional housing, so that is specifically for people coming out of residential treatment or out of jail or

prison, to have temporary housing until they can find supportive housing. And then we also have, you know, a robust supportive housing portfolio as well.

In addition, we have new regulations that we are modifying and are about to publish -- again, for recovery housing. So this is an important new part of the OASAS system. So up until this point, recovery housing has not been under the umbrella of OASAS. But this is a really important new part of our system. So we plan on publishing those regulations again soon, and then plan to make them final this year.

SENATOR FERNANDEZ: There are certain recovery groups and communities that do not qualify for Opioid Settlement funds. Would you recommend that maybe they do, given that it is a part of the recovery umbrella?

Or maybe that's a loaded question.

OASAS COMMISSIONER CUNNINGHAM: Right now we're really following the standards of State Finance Law, which require the state to use investments in voluntary and nonprofit

organizations.

SENATOR FERNANDEZ: Thank you.

And for my last 30 seconds, Commissioner of Mental Health, you mentioned investments in mental health courts, including navigators. Could you expand on that, what other investments the Governor has proposed for our mental health courts?

OMH COMMISSIONER SULLIVAN: A significant expansion of mental health courts as well, and that's in the -- in another budget but not in ours. So there will be more mental health courts.

The navigators and then, in addition, connected to the navigators is something called Forensic ACT teams. Forensic ACT teams are wraparound services for the most -- for individuals who need the most help but are not engaged in clinics.

And then the forensic navigators, Forensic ACT and 100 units of housing will all be connected for the highest-need clients.

SENATOR BROUK: Thank you,

Commissioner.

SENATOR FERNANDEZ: Thank you.

SENATOR BROUK: Next we'll hand it over to the Assembly.

CHAIRWOMAN WEINSTEIN: Thank you, Senator.

So before we go for questions, we've -- as the hearing started we were joined by Assemblymembers Santabarbara, Berger, Chandler-Waterman, Gallagher, Kelles and Anderson.

And now to our chair of the Assembly's Mental Health Committee, Assemblywoman Gunther.

ASSEMBLYWOMAN GUNTHER: Good morning, everybody, and thank you for coming.

I think we're going to hear a lot about the COLA today. And as chair of the Assembly Mental Health Committee, I will work with my colleagues to increase the Executive proposal. And right now we're at 3.2, and hopefully we can get more than that.

There's no doubt we have some promising programs being proposed by the

Executive, but I think the focus needs to be on building a workforce so we can ensure these new programs have a staff necessary to get off the ground and increase access to the service providers already operating.

Sticking with that, can you tell me specifically what is in the 1115 waiver that will help the behavioral health workforce, Ann? Sorry, I've known you so long, so I -- Commissioner. Sorry.

OMH COMMISSIONER SULLIVAN: No, no. Hello. Thank you.

The 1115 waiver has a couple of things for workforce. One is an additional loan repayment, and that will cover not just behavioral health but obviously all services -- medical, et cetera. So there's an expansion of loan repayment.

The other is a pipeline for training. And the training will include training paraprofessionals as well as some dollars for training and entry of professionals.

So there's two pieces in the 1115 waiver, are training and loan repayment for

the workforce.

ASSEMBLYWOMAN GUNTHER: How would that -- where would the training be? Would it be in the communities? Are you giving money to like hospitals or schools?

OMH COMMISSIONER SULLIVAN: I don't think that -- I mean, DOH has to talk a little bit about that. I think that the 1115 waiver stays with them.

But I think it will -- most likely it will involve working with universities and doing training in the community. They'll have an elaborate, I think, system of how to do it. But DOH is working with us on that.

ASSEMBLYWOMAN GUNTHER: You know, I was very happy at the recent expansion of the OMH Community Mental Health Practitioner Loan Repayment Program, especially the $4 million earmarked in the budget for clinicians serving children. Are you able to share an estimate of the number of practitioners that will benefit from this program? Any details, if you have them.

OMH COMMISSIONER SULLIVAN: Yeah,

we're hoping that for $4 million, somewhere in the range of 400 to 500 practitioners might be able -- it's a -- $30,000 for practitioners, $10,000 a year for three years, and then they work for three years with us.

A previous loan repayment program, which was for psychiatrists and nurse practitioners, we have already over 250 combined psychiatrists and nurse practitioners. Another rollout will get us probably another 250. So it's working. The loan repayment programs seemed to have an impact.

ASSEMBLYWOMAN GUNTHER: Okay. Also regarding school-based mental health clinics, can you provide me information on how many schools have a mental health clinic currently, and where are they located?

And can we also like find out about the process that a school would need to complete and receive funding for a mental health clinic in their schools?

OMH COMMISSIONER SULLIVAN: There are

about 1200 -- approximately 1200 school-based mental health clinics now. They are pretty much -- two-thirds are in rest of state, and one-third is in New York City. So we're working with New York City to increase that amount.

But 1200 so far. The funding in the budget is $20 million, which over the next several years can increase each year by several hundred school-based clinics.

We are also going to start a rolling application process, which would make it easier for schools at any point to come forward and then we would give them startup funds so they can begin working on developing the school mental health clinic. Those startup funds range from 25,000 to 45,000.

And then another critical thing was in last year's budget a set rate for reimbursement, both for commercial payers and Medicaid, for school-based clinics. So these clinics are now financially viable across the state once they are established in the schools.

ASSEMBLYWOMAN GUNTHER: They are very, very important to our children across New York State.

So also there will be 125 additional state-operated inpatient psychiatric beds compromised at 15 beds for children. Can you just tell us a little bit more about where, when, and how soon? How soon is really the most important part here.

OMH COMMISSIONER SULLIVAN: The beds for youth I think we can get up this year. It's not exactly finalized exactly where they will be yet. But we did add -- in last year's budget we put seven beds at Rockland Children's Psychiatric Center for kids, for youth, and 10 at Mohawk Valley.

We're looking at now where we would want to put those additional beds this year, but that hasn't quite been decided. But they will come up this year. We're looking for the space.

ASSEMBLYWOMAN GUNTHER: So I represent a county with a high rate of kids with mental health issues. And what happens is that

we're a very low income area. And, you know, parents need to be involved in recovery, both in addiction and in mental health. And a lot of times they're both involved -- you know, people self-medicate.

And so are we thinking about -- like we have community hospitals. Are we thinking about asking those hospitals where, you know, the kids reside, to, you know, open these beds? We used to have like 25 -- we used to have 25 beds in the Catskill area. Now, you know, they're few and far between, and we're sending our kids down to Rockland County, people don't have cars. It's just not working.

And in order to be recovered, we need to have things working. And we're putting a lot of money into mental health this year, but sometimes I think that we're deciding where this money goes from the top down, rather than the bottom up.

And I know we -- you know, we talk to some people, but I'm telling you, these children are not being treated and we need

more help.

OMH COMMISSIONER SULLIVAN: There's $50 million in capital -- the RFP is out -- to expand inpatient beds, new inpatient beds. And we have contacted all the hospitals to please consider as a priority -- a priority for that $50 million is youth beds. And we've contacted hospitals. We don't know yet who's going to apply, but we have talked with them about it.

In addition, over the past maybe four years the rates for inpatient services for youth have increased by over 50 percent. So they are now financially viable to have child beds. So we've made them financially viable, and now we're working with hospitals. But we're still not sure which hospitals will come to us for the 50 million -- for the capital to expand the beds.

ASSEMBLYWOMAN GUNTHER: So these local hospitals get so much money from the State of New York, and they should be mandated to serve their community. So there has to be some sort of a mandate to get it into our

community. We're shipping our kids -- the ambulances are going up and down and up and down. It's a -- it's probably a two-and-a-half-hour-drive for an ambulance. And then we have no ambulances in our community.

And that's not the way to deal with mental health, sending an ambulance to a home. So it's really -- I know you're trying but -- you know, I'm hoping the Governor is hearing my voice.

Also, can we talk a little bit about the Department of Health is proposing a 125 million cut in funding for health homes.

OMH COMMISSIONER SULLIVAN: In this budget as well as the last budget, there is support for the health homes for the most intensive work with both adults and youth. So for example, there are dollars for high-fidelity wraparound which are continuing in this budget to ensure that youth -- high-fidelity wraparound is special for youth -- will get the intensive services they need in the health homes. And also an

increase in dollars for Health Home Plus for adults.

So we are working very closely to ensure that the individuals with mental health issues who need health home services most, that they will get them. And there is support for that in the budget.

ASSEMBLYWOMAN GUNTHER: We also talk about community-based services and how many children are currently being served in the home-and-community-based. Are there many people being served in those community-based children and family treatment and support services?

OMH COMMISSIONER SULLIVAN: The home-and-community-based, yes, I think at this point for home-based crisis intervention they were up -- will be up to the availability within I think two years, probably almost 5,000 slots for that home-based, community-based waiver -- home- and community-based services.

I believe with individuals with mental health problems, about 8,000 kids are right

now being served.

So these are expanding. I think that the Intensive Services Youth Act, home-based crisis intervention, home-based children's waiver, all these are significant expansions in intensive services for youth.

ASSEMBLYWOMAN GUNTHER: Well, you know, I see in my community that, you know, our ambulances are going to the homes. And it really isn't appropriate healthcare, that's first and foremost.

And secondly, I want to say -- and hopefully the Governor's listening -- that when you're making what DSPs and people that serve our community -- as little money as they can, and they're saving lives every day. To me, 3.2, when you're making the salary that they're -- is not going to move them in a different direction.

So I really feel that we need more investments than a 3.2 percent. It's just ridiculous. It's been climbing little by little. But these are mostly women, and they provide amazing services. They're devoted.

And they really should get more than 3 percent across -- 3.2 percent across the -- it was 1.5, now it's 3.2. We asked for over 5 percent, and I think they're worthy of 5 percent because of the job that they do for so many fragile people across New York State.

So let's increase that 3.2 percent. It's only fair. We have a big budget. We do a lot of things. And you know what, they should be paying these folks that are caring for the most helpless people in our communities. So that's my last one.

CHAIRWOMAN WEINSTEIN: Thank you.

To the Senate.

SENATOR BROUK: Thank you. Before we go to our next questioner, I just want to recognize Senator Hinchey, Senator Liu and Senator Salazar have joined us this morning.

And next we will hear from our chair of the Committee on Disabilities, Senator John Mannion.

SENATOR MANNION: Thank you, Madam Chair.

Thank you, Commissioners. Thank you,

Commissioner Neifeld, for your partnership and leadership as we collectively navigate through these very -- continuing challenging times and multiple crises that we see.

The Executive Budget proposes a 1.5 percent cost-of-living adjustment. In the past what we've seen is typically the number is tied to CPI-U. But that is different as the budget has been released. Why is this year different than other years as far as connecting those two metrics?

OPWDD COMMISSIONER NEIFELD: So I think as you know, there is no requirement that the COLA be tied to the CPI-U. That was past practice and has not been the requirement in a few years.

I think what we see this year is the Governor's continued commitment, right. This is her third budget, it's the third budget that includes a cost-of-living adjustment. you know, whereas the previous administration, you know, chose not to include the cost-of-living adjustment.

So I think what we see is a real

commitment from Governor Hochul to all the agencies who benefit from a cost-of-living adjustment -- certainly the OPWDD providers.

I think we all knew going into this budget year that it was going to be a difficult budget year, there was a sizable gap, and I think the inclusion of a 1.5 percent COLA shows she's committed to continuing to support these providers on an annual basis, as she's done in her previous two budgets.

SENATOR MANNION: Thank you.

You reference the challenges that exist within the workforce, and those challenges have existed for a long time. We talk about making sure that we have -- are providing every opportunity for individuals to experience an enriched life and that there is choice involved in, you know, whatever individuals want to participate in, certain integrated settings that work best for them.

But the challenges still exist, and they exist almost exclusively around a lack of workforce.

So I've proposed, with a piece of legislation, S4127A, a $4,000 wage enhancement -- some people would call it a wage restoration -- that would go to direct support professionals and others. The estimated cost on that is $125 million, which is a significant investment.

However, it's my position -- and others' -- that it's necessary for recruitment and retention so that individuals can have choice and be able to not miss opportunities that might be out there.

So my question is -- I know that seemed like a monologue -- do you believe that a direct support wage enhancement directly to individuals from the state would be significantly helpful in meeting our recruitment and retention goals?

OPWDD COMMISSIONER NEIFELD: So let me start by saying that I think as an agency, OPWDD is interested in exploring any opportunity to support the direct support workforce. I think we, you know, are in violent agreement that the DSPs are really

the backbone of our system and are really the conduit to access to the community for people with developmental disabilities.

I don't know the details of your proposed bill, but I would be happy to make sure that our staff are available to talk with yours and obviously the Division of the Budget. When referencing, you know, a price tag like 125 million, I think it's important to think about that in the context of the budget. And, you know, happy to participate in those conversations.

I just don't know the details, and it's hard for me to sort of opine on it right here.

SENATOR MANNION: Understood. Thank you so much.

We had to close 120 state-operated residential programs throughout the COVID process. I know that there is a commitment to try to reopen those. Can you provide any update on about where we are? And if we haven't met that goal, what challenges are really preventing us from getting there?

OPWDD COMMISSIONER NEIFELD: Sure. So just a small clarification. We haven't actually closed programs. We have temporarily suspended because of predominantly workforce challenges -- not always workforce challenges; sometimes there's capital issues or other reasons why we've needed to temporarily suspend a property.

We have -- you know, we have committed to, you know, reopening those programs, bringing them back online wherever we can. In the past several years 25 of those programs have come back online and have become available to provide services.

And I think the other thing that's important to note is that in addition to those 25 coming back online, we have opened numerous other programs throughout the state. So in addition to those that have been temporarily suspended, where we are able to, because staffing allows it to be so, we have opened other programs, specialty programs, programs that are designed to fill gaps

within the system, all within the state-operated footprint.

Last year's budget, as you know, also included, you know, several million dollars to expand our intensive treatment opportunities -- so, you know, our footprint in the Finger Lakes area -- and that's in process now as well. So we are committed to continuing to open homes and programs where we can, and to certainly bringing those back online that have temporarily suspended.

SENATOR MANNION: Yes, thank you for mentioning that about the ITO. That was going to be my next question, and an update on that. As you probably hear, and certainly I think all of our offices hear about situations where individuals are hospitalized, there's no place else -- there's no place to discharge them.

So can you provide an update as far as the status of the ITO, like an expected date of opening? And if/when it does open, the expectation is that it will be at full capacity?

OPWDD COMMISSIONER NEIFELD: Sure. It is a multiyear project. So the status is that it will open I think sometime within '25. But I can confirm that and get back to you.

There is currently a capital RFP out right now, so we'll be expecting bids to come back to us on -- you know, to inform the renovation and rehabilitation of the building in the Finger Lakes area. So that's where we are on that project right now.

SENATOR MANNION: Thank you.

This could go to a couple of different commissioners. But we had talked a little bit about dual diagnoses throughout this process here. And at Upstate we have 11 dual-diagnosis beds.

Where are we exactly with the status of those? And is there, you know, either of the agencies looking to expand that number and increase the number of those inpatient beds throughout the state?

OMH COMMISSIONER SULLIVAN: In terms of the beds at Upstate, we're very hopeful

that the construction and necessary work will be done in this year. I know there have been delays, but this has been a real project that we're been working very closely together with OPWDD on the design and implementation.

It will also have a step-down unit. Once the unit opens, something similar to Our Lady of Victory, OLV's step-down unit. So that will also be there as well. So we're very hopeful that we'll have that this year.

In terms of expansion, a critical piece of last year's budget was something called transitional beds, and critical time intervention teams that wrap around those beds for youth, especially. Those are going to be opened across the state, probably one in each Economic Development Region, 10 teams with those beds of -- 900 beds, about a hundred dedicated to youth.

Those will be -- some of those will be specifically targeted to work with individuals with dual diagnoses, so we can get them from emergency room to transitional beds. And then there's an adult component

which is very similar, from emergency to transitional beds, hopefully getting people back quickly into the community.

OPWDD COMMISSIONER NEIFELD: And then I would just add, on the OPWDD side, we're also working with one of our providers in the Hudson Valley to open a statewide resource, a children's specialty hospital that's designed -- there will be a small number of beds to serve medically fragile children, and then also 12 beds for children with behavioral challenges, primarily individuals with an autism diagnosis.

And we're expecting that to open within 2024. And it will be located in the Hudson Valley, but it will be a statewide resource, working with all of the various referral sources. And it's meant to be short-term intervention. The primary goal is return to home, return to family, return to community.

SENATOR MANNION: Thank you for those answers. I appreciate it.

On -- Commissioner Neifeld, you

mentioned credentialing for DSPs. Is there currently any mechanism for supporting that credentialing with a stipend or anything else? Or is that something that the office would consider?

OPWDD COMMISSIONER NEIFELD: Individuals who participate in the credentialing program, we offer that two different ways. One is through a contract that we have with providers, and providers can sponsor their staff. And then we're also working and partnering with SUNY. We're on 13 campuses, and we'll be expanding.

So through both of those programs, there is a stipend attached to the individual who goes through the credentialing program. And as I mentioned in my testimony, for those who are pursuing it through the community college system there are also college credits that are associated with that microcredential. So it's been very successful and has really supported the DSPs in multiple ways.

SENATOR MANNION: Thank you,

Commissioner. Thank you, Madam Chair.

CHAIRWOMAN WEINSTEIN: We go to the chair of Alcoholism, Assemblyman Steck.

ASSEMBLYMAN STECK: Thank you very much, Madam Chair.

Good morning, Dr. Cunningham. I have a few questions to follow up on some of your remarks.

And you indicated that certain amounts of funds have been made available from the Opioid Settlement Fund. My understanding is "made available" is different from them actually being in the hands of providers. In other words, you make them available and then there's a process that the providers have to go through to actually access the funds. Is that correct?

OASAS COMMISSIONER CUNNINGHAM: Yes. I mean, we follow State Finance Law to be able to, you know, go through that process of procurements, contracting and awards.

ASSEMBLYMAN STECK: And of -- let's say in 2022-2023 the figure you used was that 192 million had been made available. How

much of that money is actually in the hands of providers?

OASAS COMMISSIONER CUNNINGHAM: So I just want to start off by saying that, you know, in New York we've made more money available more quickly than any other state in the country in terms of Opioid Settlement funds.

Also, we've heard from providers --

ASSEMBLYMAN STECK: My problem is I'm an attorney, and that's nonresponsive to the question.

The question is, how much is in the hands of providers? Not whether you've made more available than any other state.

OASAS COMMISSIONER CUNNINGHAM: So what we heard from providers is that sustainability was a really big issue. For that reason, we have multiyear initiatives. So we would not expect that all of the dollars would be in their hands in Year 1. So that the dollars are disbursed over several years.

So all of the dollars are available in

terms of contracted and awarded, but we wouldn't expect that all of those would be in the hands of the providers in Year 1 because this is happening over multiple years.

ASSEMBLYMAN STECK: I understand that. But are you saying you just don't know how much is actually in the hands of providers? You've explained the process, but my question was how much is actually in the hands of providers.

OASAS COMMISSIONER CUNNINGHAM: Right. Well, I mean, I have to say they are in various stages of the process. And, you know, we are right now distributing about $15 million every quarter, but it really -- it depends on the multiyear initiatives, and so some of them go out three years or even further.

ASSEMBLYMAN STECK: So let's go now to the issue of workforce. We've all acknowledged the workforce problems.

Are any of the Opioid Settlement funds being used to address workforce?

OASAS COMMISSIONER CUNNINGHAM:

Absolutely. So in fiscal year '23 we provided $13 million of scholarships, so that is for supporting those to become credentialed counselors, prevention professionals, and for the peer workforce.

In addition, we just released a new RFP now that is for a leadership institute and also for paid internships. So that's from the Opioid Settlement funds.

In addition, we expect that additional funding will be available from fiscal year '24, Opioid Settlement funds to continue to support the workforce.

ASSEMBLYMAN STECK: So when we held hearings on the issue of workforce, the -- one of the difficulties was that not-for-profits generally cannot pay as much as the state can or provide the type of benefits that the state can to attract people to this field at higher levels of professional qualification.

Do you have any plans to address that issue? Or are you strictly talking about giving scholarships to train people who

already work there to up their credentials?

OASAS COMMISSIONER CUNNINGHAM: So we are really supporting the workforce in various ways. So supporting the workforce as it currently exists, and then trying to bring more people into the addiction field as well.

So we're doing that through multiple ways. Some of it is scholarships or paid internships; some of it is through raising Medicaid rates. So that is certainly a sustainable way, you know, to increase the salaries, in addition to the cost-of-living adjustments.

So there are many ways that we're supporting the existing workforce, and then trying to attract people to the field as well.

ASSEMBLYMAN STECK: So the providers generally complain that the Medicaid rates are not being increased. You say that you're increasing them. What have you done specifically to increase the Medicaid rates?

OASAS COMMISSIONER CUNNINGHAM: So we have increased the rates that range between

5 and 15 percent across the system. So it really depends on the specific type of program and the location of the program. But really, across the board, we have increased the Medicaid rate.

ASSEMBLYMAN STECK: So the OASAS budget appears to be -- to us, to be $179 million less than last year. And what is the reason for that?

OASAS COMMISSIONER CUNNINGHAM: The majority of the reason for that is actually the reduction in the Opioid Settlement funds.

So from these past two years, the budget, you know, was around 200 million and now it's dropped to 63 million. We expected this. We knew this would happen in terms of the Opioid Settlement funds. And that's part of the reason why we've had multiyear initiatives, is to ensure that the services are not cut.

So the services won't be cut, so on the ground programs will not feel a cut. But in fact the services will continue through these multiyear contracts with the fiscal

year '23 and '24 Opioid Settlement funds.

ASSEMBLYMAN STECK: So there are budget cuts for ancillary services such as transportation, job search, and you had -- and that's definitely in the Governor's budget. But you had indicated that you are also increasing some of that funding through the Opioid Settlement Fund.

OASAS COMMISSIONER CUNNINGHAM: That's correct.

ASSEMBLYMAN STECK: The problem is that the Opioid Settlement Fund is not supposed to displace existing state funding. And when you are saying that the -- you are using the funds to -- the settlement funds to -- and at the same time cutting existing state funding for those type of services, it certainly suggests that the funds are displacing existing state funding in those areas.

Do you agree or disagree?

OASAS COMMISSIONER CUNNINGHAM: The funds are not displacing or supplanting state funds. We are continuing to enhance

programs. So, for example, for transportation programs we're continuing to enhance them and support them with the Opioid Settlement funds.

ASSEMBLYMAN STECK: But the regular state funding for those things is being reduced, isn't that correct?

OASAS COMMISSIONER CUNNINGHAM: We are not supplanting funds through Opioid Settlement dollars.

ASSEMBLYMAN STECK: But are the existing state fundings, as per the Governor's budget for transportation, job search, those sorts of ancillary services, being reduced, yes or no?

OASAS COMMISSIONER CUNNINGHAM: Not for transportation, but yes for some of the job placement functions, yes.

And those are also available through other state agencies. Those are not some of the core missions in terms of OASAS.

ASSEMBLYMAN STECK: So the -- I want to talk a little bit about marijuana, which you mentioned, and you talked about the

impact on youth and so forth. I want to focus a little bit on the impact on adults.

So we in my district have had instances of people being hospitalized with marijuana-induced psychosis, we've had other people for whom cannabis use has triggered descent into mental illness.

You're a physician. Some physicians -- I mean, I'm not a physician, I don't know the wide variety of opinions in the medical community. But as a physician, do you agree that marijuana-induced psychosis is a real phenomenon with respect to adults?

OASAS COMMISSIONER CUNNINGHAM: Certainly, you know, there are effects that cannabis can have. So cannabis use has been increased with some mental health conditions, including psychosis. It is not so common, and it tends to depend on the amount of use and the amount of THC.

ASSEMBLYMAN STECK: So you would agree that the amount of THC is a relevant factor in whether that occurs or does not occur.

OASAS COMMISSIONER CUNNINGHAM: Yes.

ASSEMBLYMAN STECK: And would that suggest that perhaps the THC content of cannabis at dispensaries should be regulated like we regulate the alcohol content of alcoholic beverages?

OASAS COMMISSIONER CUNNINGHAM: I mean, you know, that is something that we don't do in the office, in our office, right? It's a different agency. But we certainly are there to provide education and prevention and treatment when needed.

ASSEMBLYMAN STECK: One question for the commissioner of Mental Health, and that is we talk a lot about the behavioral health centers, community health centers. We talk a lot about the Governor's increase in hospital beds for mental health. We've also heard about transitional care, which to my understanding is very short. The question is, is there a commitment to transitional care that would get people from hospital beds into independent living that lasts for, say, 90 days or more?

CHAIRWOMAN WEINSTEIN: And

Commissioner, you'll have to send that to the -- that response to the two chairs of Assembly Ways and Means and Senate Finance.

And there may be other questions, as time goes on, that there are not opportunities to answer within the time frame. And then we will make sure to circulate them to all the members.

Before I turn it over to the Senate, I just wanted to mention we've been joined by the ranker on Disabilities, Assemblywoman Jodi Giglio.

Senator?

SENATOR O'MARA: Yeah, I just want to announce that we've been joined on our side by Senators Bill Weber and Patricia Canzoneri-Fitzpatrick.

SENATOR BROUK: Wonderful. Hello again, Commissioners.

So I will use my 10 minutes as -- in the Mental Health chair position. First I want to talk about crisis. We're doing a lot in this year's budget and the Executive proposal around mental health crisis and

obviously youth mental health. You know, we started a couple of years ago hearing from our Surgeon General that this is the crisis of our lifetime.

I want to thank the commissioners and the Governor for understanding that crisis, and so much in this Executive proposal highlights how we can respond. Of course there's always more we could do, so that's where we're going to dig in.

And so I'm going to start with some of the work that's being done around crisis specifically when it pertains to Daniel's Law and the Daniel's Law task force. So I do want to say just a huge token of gratitude to Commissioner Cunningham and Commissioner Sullivan for the earnest work that you both are putting into that task force and making sure that it's moving forward.

My question is specifically for Commissioner Sullivan, though. In the work that you're seeing and a lot of the feedback you've been getting, both from the public commentary but also from the task force

themselves, do you agree that there is an urgency to move perhaps even quicker than -- I think it's a 2025 deadline for getting this task force to completion. Do you believe there's a world in which we could get some of these recommendations before then?

OMH COMMISSIONER SULLIVAN: Yes, I think we're going to be working -- the task force has also expressed an interest in that urgency, as you say. So we are working as quickly as we can. And we're very -- we're going to try to see if we can do things much sooner than the December 25 deadline, which was the initial -- in the legislation.

SENATOR BROUK: That's great to hear.

And on that note, I wanted to see if you were familiar with a case -- a lawsuit against Washington County, Oregon, and its 911 dispatch center. So the ACLU announced a lawsuit essentially around a gentleman who called a crisis helpline, did not receive the care he was expecting. Instead, law enforcement showed up, he was having suicidal ideation at the time, this gentleman was.

And unfortunately for him, due to that lack of an appropriate crisis response, he ended up in the hospital for two weeks and even serving jail time.

And again this is from, you know, someone who was having suicide ideation, called what he believed was a crisis helpline. And here in New York we have 988 as well. But unfortunately, the system was not in place to make sure that a mental health provider appeared, a social worker showed up, and instead it was law enforcement that inherently ended up escalating the situation.

So as we look at, you know, current -- you know, current lawsuits and -- I don't know, would we fear that something like this might happen here in New York if we aren't able to put in this statewide framework that Daniel's Law would be able to put into place?

OMH COMMISSIONER SULLIVAN: Well, a critical piece is going to be what number is called. And then, at the point someone calls for help, how that call is triaged to who.

And when you look at the programs across the nation, that's the critical piece.

So if you call 988 now, I mean, in New York less than 0.3 percent of any of the calls to 988 -- and last year we had almost 200,000 calls -- go to 911. And some of those are for medical, some of those are for police. So a very small percentage of 988 ever translates.

When you look at some of the models across the country, like a "who" switch is a model that everyone is looking at. Calls go into a dispatch center and then the dispatch center determines whether or not that individual goes for mental health services, to medical, if they need that, or to law enforcement.

So the key point is that dispatch center. And I think that's what the task force is looking at, how do we determine -- and we want to do it right in New York -- how do we determine who gets siphoned off to which services and ensuring that if it's a behavioral health crisis, the vast, vast

majority of times it will go to a behavioral health team of some sort, which we're still looking at models to develop.

SENATOR BROUK: And I would say -- I know you've got folks doing this work, but I know in North Carolina they also have a similar program to CAHOOTS that I hope earns the consideration of the task force.

And so I don't think that there's an argument at this point. It sounds like including from you, commissioner, that we know we need these types of mental health providers showing up. And unfortunately, you know, we talk about a lawsuit like that, which is what makes the headline -- but that also means that that gentleman's life has been re-traumatized after an initial trauma as well.

So I want to pivot to talk about the youth mental health crisis. So I want to commend you, Commissioner, for everything you've been doing with the school-based centers. I think it's a tremendous investment that we're making that the

Governor has put in.

The thing that I am concerned about is in my district we've started our Youth Mental Health Advisory Board. And I know that we think that perhaps this has destigmatized services that we're giving young people in their schools, but there's still a bit of a barrier where you may not want to partake in this kind of service in school.

So we've been looking at, based on their recommendations, other opportunities for meeting young people where they're at.

Have you or anyone at OMH looked at the program in Colorado called "I Matter," which offers six free tele-mental health -- or in-person, if they choose -- for any young person? We've looked at proposals like that over the last couple of years. I have a bill that would call for a pilot.

Is that anything that you all have considered, of really trying to bring more services to young people?

OMH COMMISSIONER SULLIVAN: I think it's interesting to look at that. And I

think we have been talking about it. We're not at a point yet where we have decided whether or not to implement it.

The availability -- we do have the availability of 988, of crisis text lines. In the schools we are doing a lot of work with peers. So, for example, what we call Team Mental Health. So some of the best ways to help kids is to have their peers involved. And Team Mental Health is something that we're going to be expanding across the school system. And that peer involvement changes the cultures in schools, but it also decreases the stigma and youth not wanting to -- being afraid to call.

We do have easy access through 988, and that's being talked about in schools, and "text through 988."

The tele is still -- we're still looking at that.

SENATOR BROUK: Okay. And I would love to talk about it more, because I think that it's something -- you know, I think a lot of times we think that one -- we can

just, you know, check the box and one program's going to work. But there are so many young people who are in need of help.

And, you know, I think of the Healthy Minds, Healthy Kids study that just showed that one in two New York youth with major depressive episodes in the past year did not get treatment.

And when you think about that on top of one in five children in New York who need mental health services, obviously we've got to kind of throw everything at this problem that we have.

So I want to use the last couple of minutes to talk about CPEP. And so, you know, the psychiatric emergency departments, we have one in my area in Rochester, New York. And I notice that in the Executive Budget proposal there is a proposal to make this extension permanent for CPEPs.

But I do wonder if we've really looked critically -- obviously there's a need for CPEP, there's a need for people with that who are in crisis and either a danger to

themselves or others that need to be in the CPEP.

But we also see that when youth are entering those doors, a lot of times parents don't realize that they're made to stay there.

I heard a story the other day about a young person who went to a CPEP, was kept for 48 hours without their family, and then, you know, discharged and sent to a community-based center. Obviously that person did not need to go inpatient. Now that child's re-traumatized.

So what are we doing to -- of course if we need to have CPEPs, let's have them -- but to also assess perhaps they're not the only answer. And when I think about what we did a couple of years ago with the crisis stabilization centers, perhaps that is something we need to be looking at specifically as it comes to youth.

So I'm curious what assessments have been done around CPEP specifically for youth, and then what do these crisis stabilization

centers look like right now, where are we in the process of building those, and are they applicable to youth?

OMH COMMISSIONER SULLIVAN: Yeah, we follow very closely what's happening in the CPEPs. And what we would like the CPEPs to be are there for the individuals who need the most acute and the most intensive intervention.

So we've been building the rest of the system, as you appropriately say, to be able to have youth who maybe don't need that to be able to go to other services. So one, for example, is the stabilization centers. There's going to be 13 of the intensive across the state; I think two or three more opening up this year. Some of it was capital.

Those stabilization centers will have up to 24 hours; heavily peer and family advocates present in those stabilization centers to work with families when they come in. And all the stabilization centers will have both youth and adult services. So we're

very excited about that.

We also have grown home-based services for youth in a big way. So that basically -- it was unfortunate, perhaps, that that individual maybe stayed for 48 hours, but we're working on now is having home-based crisis intervention services, which are growing across the state, so they can go right home with the youth, with the family, and work with them for a period of time to stabilize the family without having to have inpatient services.

So you really need a continuum from the most acute -- unfortunately, CPEPs -- sometimes people go because we haven't had the other pieces of the system. So by growing the crisis stabilization centers -- also the certified community behavioral health centers have outreach programs for youth and have intensive services for youth.

So as the continuum grows, hopefully youth and families will have these other opportunities. And then only when absolutely necessary, a CPEP and possibly admission to

an inpatient unit.

SENATOR BROUK: Thank you.

So in my last ten seconds, I would just ask, you know, as we are moving forward these proposals, of course we want to look at that moment of crisis, but that continuum of care, right. And so even the 0.3 percent you mentioned for 988, we need to do more education to make sure people are even calling 988.

OMH COMMISSIONER SULLIVAN: Absolutely.

SENATOR BROUK: So thank you so much.

OMH COMMISSIONER SULLIVAN: Thank you.

CHAIRWOMAN WEINSTEIN: We've been joined by Assemblywoman Darling.

And now we go to Assemblymember Seawright for 10 minutes, our Disabilities chair.

ASSEMBLYWOMAN SEAWRIGHT: Thank you, Chair Weinstein.

And good morning, Commissioners Neifeld, Cunningham and Sullivan. Thank you for your testimony today. With Women's

History Month approaching, it's nice to see three good women leaders at the table.

Commissioner Neifeld, I appreciate your leadership, and Greg Roberts and your team's work during these very challenging times. New Yorkers with intellectual and developmental disabilities have suffered the consequences of over a decade of disinvestment and are at risk of being cast aside without protection.

If I were a doctor assessing our state's crisis, experienced by 85 percent of the people with disabilities, supported by nonprofits, I would discover the following: The diagnosis of prior agencies hemorrhaging workers. They simply cannot serve the demands of a fragile population in the face of an annual 30 percent workforce turnover and agency vacancies in excess of 17 percent.

The cause, from a historic and predatory pattern of wage stagnation and disparity between nonprofit providers and their state counterparts. The symptoms, being rampant and pervasive with direct

support professionals fleeing for better and less demanding jobs in retail and fast food.

All of this means that I/DD New Yorkers are going without -- without daily support, first aid, CPR, administering medications, meal preparation, transportation, and social, emotional and psychological support.

It is very concerning to be hearing from families, advocates and constituents that OPWDD's regulations are being made without family input -- specifically, the Family Support Services Program. Participants are enduring hardships as family caregivers are being disqualified to care for their loved ones despite a shortage of DSPs in the workforce. Agencies are closing these vital programs, and I/DD New Yorkers are being pushed further toward exclusion, isolation and institutionalization, the absolute antithesis of the promise of the Olmstead decision.

The prognosis is $100.5 million annually lost by providers; a depleted and

anemic system burdened by the increasing rate of inflation and cost of living. Costs are rising, and agencies must maintain benefits -- maintenance, utilities, food, supplies, transportation and insurance.

Commissioner Neifeld, in your testimony you stated there is no single solution to the current workforce crisis. I would suggest that there is a solution, and that is a financial investment in our hardworking workers and workforce. I would prescribe the treatment of implementing no less than a 3.2 percent COLA to support agency rates and restore care coordination among organizations to offset rising inflationary costs.

I strongly reject the 1.5 percent COLA in the Executive Budget which we've already heard so much about this morning from my colleagues. Abandoning I/DD New Yorkers and the hardworking professionals who are largely women of color is negligent. We need the lifesaving infusion of a direct support wage enhancement that will only begin to move the

system toward equity with a $4,000 increase annually to DSP workers that I'm pleased to be sponsoring along with Chair Mannion.

The DSPs are a lifeline to people with disabilities who need the dignity of their independence, and workers need the dignity of a fair wage for their skills and care. The system is suffering.

I'd like to lead off my questions this morning to Commissioner Neifeld and start with my first question. To close the midyear budget gap, agencies were to come up with a savings plan as a follow-up. I'd like to know the total amount that OPWDD had to come up with and what programs were impacted by this action.

OPWDD COMMISSIONER NEIFELD: Thank you. All state agencies work, you know, closely with the Division of the Budget throughout the year to monitor our spending to understand, you know, what's happening with our agencies' budgets.

I don't know the total off the top of my head related to the midyear, but what I do

know is that there were no -- there was no impact to the services and supports that we provide to people with developmental disabilities, so there was no reduction in any of our appropriation for services or our Medicaid spend or anything like that.

Like I said, I can follow up with you with sort of the specifics in that total, but there was no impact to services for people.

ASSEMBLYWOMAN SEAWRIGHT: Every year we talk about the need for a cost-of-living adjustment to support programs across several agencies and to maintain services for people. This year the Governor proposed a 1.5 percent COLA, which is less than half of the Consumer Price Index, the measure that has historically been used.

Are you concerned that this is not sufficient to support programs given the level of inflation?

OPWDD COMMISSIONER NEIFELD: I think that, again, taken in totality, right, with the last three years of cost-of-living adjustments, we're looking at close to a

10 percent cost-of-living adjustment over the first three years that Governor Hochul has issued budgets. And that's, like I said, close to $1 billion going directly to OPWDD providers in the last three years.

In addition, this year -- I mentioned in my testimony that we are doing a rate rebasing, which means that we're looking at the rates that we pay to providers and making sure that they're more reflective of updated costs of doing business.

Currently the rates are based on I think 2017 cost information, so we'll be updating that to be much more current, which will also help to provide additional funds going to providers, an additional $350 million on top of the cost-of-living adjustment that will help offset those increased costs that you've referenced.

ASSEMBLYWOMAN SEAWRIGHT: Are there any efforts to increase the wages for DSPs who work for nonprofit service providers?

OPWDD COMMISSIONER NEIFELD: Everything that we've just talked about --

the cost-of-living adjustments over the last three years, the rate rebasing, the expectation is that providers are using to go towards increasing wages for their direct support, their clinical staff, those who are working with people with developmental disabilities.

I think we know that there are other costs that providers incur, the costs to run a program. But the majority of what they pay, what their operating budgets are, consists of personnel, and the majority of that personnel is direct support staff.

So we do expect to see a large portion of those investments go towards staff wages.

ASSEMBLYWOMAN SEAWRIGHT: But then they're going to be cutting somewhere else and harmed in other areas.

The Executive -- over the past few years OPWDD employed direct support professionals and they've seen an increase in their starting pay, which is about $27 per hour in New York City, $25 per hour for the rest of the state, while at the same time the

starting rate for a DSP providing the same services to the same population, but employed by a nonprofit, starts at $17 an hour in New York City and 16.48 per hour elsewhere.

Can you explain why there is almost a 50 percent differential pay between the two systems?

OPWDD COMMISSIONER NEIFELD: I think it's important to start off with saying that we value the work of our voluntary providers. As you mentioned, they're serving, you know, 80 percent or more of people with developmental disabilities. And we certainly value the work that the DSPs who are employed by those providers do.

All of the initiatives that I have talked about this morning -- the cost-of-living adjustment, the rate rebasing, our work with the National Alliance for Direct Support Professionals -- in the past two years or three years we have spent, you know, well over a billion dollars in bonuses, in staff bonuses, both through our ARPA funding and through the Governor's Healthcare

Worker Bonus Program. All of that has gone directly to the voluntary system, directly to direct support professionals.

So we are working I think every angle in trying to support the direct support workforce, to provide the funds to providers to enhance the wages. We do not set the wages for direct support professionals in the voluntary sector. We are not their employer, so we don't have the ability that we do within state operations to set wages.

ASSEMBLYWOMAN SEAWRIGHT: Let me stop you there because I'm running out of time and I have more questions.

What kind of residential opportunities will be developed with the funding that's proposed in the Governor's Executive Budget?

OPWDD COMMISSIONER NEIFELD: So everything that we do, all of our services are person-centered. We look at the needs of individuals and develop opportunities based on those needs.

As an example, within state operations we have spent time over the last two years

developing what we call adult transitional homes, which are meant to help support students who are leaving residential schools and entering into the OPWDD system, which is a difficult transitional time.

That's just an example of a development that we've invested in based on need.

ASSEMBLYWOMAN SEAWRIGHT: With the funding support, will there be any reopening of previous closed group homes that I believe earlier today, in your testimony, you said are not permanently closed but temporarily?

OPWDD COMMISSIONER NEIFELD: Those temporary suspensions, we look to reopen programs that are temporarily suspended when we have staffing in the region that is available to support the operations of those programs.

ASSEMBLYWOMAN SEAWRIGHT: On self-direction. Although no new directives have come from -- I'll save this for the second round.

CHAIRWOMAN WEINSTEIN: I was going to

say -- thank you. To the Senate.

I don't know if we explained that when the yellow light goes on, that means there's -- that's your one-minute warning before the bell.

To the Senate.

SENATOR BROUK: Thank you.

Next we'll hear from Senator Oberacker, who's a ranker, so he'll get five minutes.

SENATOR OBERACKER: Good morning. Good to see everybody here in Albany. And you didn't have to fight through the white stuff to get here, so that's always a good day to start here in Albany.

Just some real quick background and some foundation. I represent the 51st Senate District, seven counties, the second-largest in New York. Senator Stec and I go back and forth as to who has the largest, but I will concede the second-largest. One of those counties is Sullivan County. Sullivan County has the distinction of a 245 percent higher rate of overdose than the New York State

average -- a distinction, of course, that we would like to see changed. And some ideas that, moving forward, I would like to propose to see that those would be addressed.

And before I go too far, I would like to take a moment to say thank you to Assemblywoman Aileen Gunther, who has worked with me on a lot of these issues. And it's nice to have a partner, if you will, in that county.

So we've heard a lot of talk today about mental health, school-based mental health, school-based health centers. First and foremost, I'd like to see us change -- I think I brought this up last time. Instead of saying school-based health or school-based mental health, I'd like to see us say school-based or -- school-based wellness centers.

I think there's a stigma that goes -- especially with the mental health side of things, which I think we can change that direction there. It falls under our youth prevention programs, as

Commissioner Cunningham has talked about.

In Otsego County I have 11 school-based wellness centers in Otsego County. What I'm asking is this. Between the two commissioners, couldn't we get together and provide both mental wellness and school-based situations? They're already there, the framework is there. You know, and the company that I had -- we used to say find something successful and copy it. I think we have a framework there. I'd like to see us potentially work together in extending our mental health side with already school-based centers that are there.

Along with that, one of the projects that we've been able to put into Otsego County is called One Box. It's a one box project. This is actually an AED for overdose. I don't know if you're familiar with this or not. It was through our lead counsel in Otsego County. It contains Narcan, PPE equipment. It has a drop-down screen which is a preloaded 60-second video, step by step, to help someone address an

overdose. And it's also bilingual.

I think this is one of the best and most innovative solutions that I've seen in a very long time. And I think this is how our settlement monies should be used within that district.

So, Commissioner Cunningham, with some of this information would you be willing to work with me in my district, and more appropriately in Sullivan County, to see if we can't use some of these areas that I've just talked about and see if we can't institute those there?

OASAS COMMISSIONER CUNNINGHAM: Of course, Senator Oberacker. You know, I appreciate, you know, knowing Sullivan County with the distinction of having the highest overdose death rate. And as you know, I went to your district at the town hall to really listen to what community members had to say about how we can help to better address the overdose epidemic.

I totally agree about the settlement funds. I mean, as you know, all the local

government units also got settlement funds, so 64 million in fiscal year '23, and then 46 million more recently, to do all these innovative things. And so we're very happy to support that and also happy to, you know, contribute to naloxone, fentanyl test strips, xylazine test strips, as tools to be able to really address that overdose epidemic.

SENATOR OBERACKER: I appreciate that, and I truly look forward to working with you in this ensuing legislative year.

So with that, I will concede back my 34 seconds, Madam Chair.

CHAIRWOMAN WEINSTEIN: Thank you.

We're going to go to Assemblyman Brown, the ranker, for five minutes.

ASSEMBLYMAN KEITH BROWN: Thank you, Chair.

Before I get started, I just wanted to make a comment. I want to say on the record that I'm not sure combining three commissioners for three agencies with a combined appropriation of $9 billion -- 4 percent of the State Budget -- and giving

five minutes to ask questions on topics involving our mental health and substance abuse state of emergency makes a lot of sense.

But with that said, I'm going to use my time as best I can.

First of all, thank you so much for your hard work. First, the public relations campaign -- just this morning I saw in my hotel room on TV commercials from OASAS. And also during the Super Bowl, I saw a commercial. And I really also appreciated the bullying commercials. I think there were two bullying commercials I saw, sponsored by the NFL, which I thought was appropriate to mention.

But I also want to extend my invitation to the Co-Occurring Disorder Conference that we're scheduled for April 11th. Both of you were kind enough to come last year. I invite all the members of the committees to come. It was an extraordinary day, 250 participants.

With that said, I'd like to focus on a

couple of the portions of the budget; namely, the $11.4 million cut in the Chemical Dependency Outpatient Treatment Support Services and Community Services Program.

And also on the Opioid Stewardship funds, which my colleague Chair Steck mentioned yesterday he has a bill to audit that, the $167 million that's left in that account. And if we can get a full accounting of what's left in the account, what the money was spent on over the years, and what the remaining money will be spent on.

And I also want to bring up the Co-Occurring Disorder Report that came out of last year's conference that I forwarded to you, if you had a chance to look at the recommendations.

But my question for this morning, the New York State Council of Community Behavioral Healthcare came out with a memo, and I just want to quote some of it. It says: We have a serious shortage, 21 percent annually, in waiting lists for services, including but not limited to

medication-assisted treatment, children's community services, and outpatient care.

The memo goes on to say: Fortunately, the Hochul administration began to recoup from MCOs; $222 million was returned to OASAS and OMH for a two-year period of overpayments to plans, with additional funding being recouped going forward.

So with that, I'm sure you saw the Office of Attorney General came out with a scathing report on December 7th of last year making several recommendations, and I wanted to get your opinion on them. I'm just going to read from page 5 of the executive summary. It says: "The OAG's survey confirms the need for regulatory changes, increased enforcement and significant actions by healthcare plans. New York should (1) require health plans to conduct regular audits of their provider networks to verify compliance with directory accuracy; (2) mandate robust appointment wait time standards; (3) require health plans to analyze and submit to regulators data regarding key network adequacy indicators;

(4) require health plans to improve inadequate networks and improve consumer complaint mechanisms; and last, explore the possibility of a centralized provider directory for all health plans."

She concludes by saying: "Health plans must also proactively improve their practices, including by recruiting more mental health providers into the networks, especially providers of color; increasing provider reimbursement rates, and decreasing administrative burdens on providers. Only a multifaceted approach can effectively address the unmet needs for mental health treatment in New York."

The report does not paint a good picture in terms of what we're doing to get people help. So I ask, have you seen the report and reviewed the recommendations? Both commissioners.

OMH COMMISSIONER SULLIVAN: Yes, we have seen the report. And there's a couple of very important things that are happening.

The Department of Financial Services

has regulations which are out now, which are for a comment period, that would require a 10-day appointment time. In other words, providers of plans both would have to find a mental health or substance abuse appointment within 10 days.

In addition, if they don't find a provider, they would have to pay for out-of-network services with no increased cost to the individual. So that's one of the DFS regulations, which comes directly.

The other is directories have to be updated and kept current. And that's also in response to problems which have existed for many years in terms of phantom directories which have not really had providers available.

So those DFS regulations are currently out for comment. So that is one way to begin to --

ASSEMBLYMAN KEITH BROWN: I think you can finish the sentence.

OMH COMMISSIONER SULLIVAN: The other is what's actually in the legislation, this

year what the Governor's asking for is that --

CHAIRWOMAN WEINSTEIN: Thank you, Commissioner.

So I know Mr. Brown read a lot of that information. So we would hope that after the hearing all of you will be able to respond in writing, not just to Mr. Brown but to the chairs, so we can share with all of the colleagues who are here.

OMH COMMISSIONER SULLIVAN: Be glad to.

CHAIRWOMAN WEINSTEIN: So now we go to the Senate.

SENATOR BROUK: Thank you.

Senator Hinchey.

SENATOR HINCHEY: Thank you, Madam Chair.

And thank you all for being here and for the incredibly important work that you all do.

I want to start, though, with saying that Assemblymember Gunther is entirely right. Our rural regions are vastly

underserved. I have a constituent who was 16 years old when she received a TBI, a traumatic brain injury, and had to move out of the Hudson Valley to Long Island to receive services. She still cannot come back. She actually had to leave the state, but that's a different conversation.

On December 6th -- Commissioner Sullivan now -- on December 6th the Governor announced millions of dollars in funding to expand 13 new clinics across the state for mental health and behavioral health services, and notably absent was the Mid-Hudson Valley, because, respectfully, one center in Westchester does not actually serve the majority of the Mid-Hudson Valley.

And so my question is knowing that especially places like Kingston and our area are in deep need of mental health services, why were we left out of this expansive list?

OMH COMMISSIONER SULLIVAN: That was the first list that's coming out. There's an additional 13 that are coming out very soon, for a follow-up. So there's definitely

consideration to increase in the second round.

SENATOR HINCHEY: We are -- in my office particularly, many others are in direct conversation with OMH and the Executive's office on the need for these beds. Quite frankly, on December 6th I was on the phone with the second floor. And so in the first round not being included, is that a guarantee that at least --

OMH COMMISSIONER SULLIVAN: No, we're looking at the data, but -- we're looking at the data to see, yes, but we are looking again to see where the most need is. You're talking about the Certified Community Behavioral Health Centers, I believe?

SENATOR HINCHEY: Yes.

OMH COMMISSIONER SULLIVAN: Yes. So there's an additional 13 that are coming out, and they will again be in areas that weren't in the first 13.

SENATOR HINCHEY: Wonderful. I look forward to at least one of those being in or around the four counties and 3,000 square

miles that I represent that we know are in desperate need.

Next question, for Commissioner Neifeld. You mentioned earlier to Senator Mannion about the short-term intervention program being placed hopefully in the Hudson Valley. My question would be, are you looking at -- knowing that the type of services that we need are not there, where in the Hudson Valley are you seeking?

OPWDD COMMISSIONER NEIFELD: So that's a provider that's located in Sullivan County, but I just want to emphasize that it is a statewide resource, so it won't be only serving individuals who live within Sullivan or within the Hudson Valley. We'll be looking based on need at referrals from school districts, from hospitals, from the Council on Children and Family, to serve people there.

SENATOR HINCHEY: Right. Looking at our district, though, I mean at least Sullivan County would be something that would be close to the constituents that I serve,

knowing that we've had many people that have had to actively leave.

I look forward to continuing the conversations to make sure we can have more services in our area so people don't have to leave to Long Island, let alone leave the state altogether.

Thank you.

CHAIRWOMAN WEINSTEIN: So we go to Assemblywoman Giglio, five minutes, ranker.

ASSEMBLYWOMAN GIGLIO: Thank you.

Thank you, Commissioner. You're a breath of fresh air.

So my question has to do with the 20 percent loss in DSPs throughout the state and through the group homes and the initiatives that OPWDD are working so diligently on, and how to fill those positions.

You know, the budget is really the only way to do that, and the 1.5 percent COLA, even though there have been significant increases over the last three years, it's not enough to make up for the 10 years that there

were no increases at all.

So to catch up to that, I mean, last year the one-house bills proposed an 8 percent increase in both the Assembly and the Senate, and I think that it was a bipartisan effort to make sure that our vulnerable population is taken care of. And that was cut in half.

So the high expectations, the high cost of living, the increase in costs for the group homes and for the not-for-profits that are taking care of our most vulnerable population, as my dear friend Rebecca Seawright brought up, the chair, is an ongoing problem. And we're losing DSPs to other jobs with the minimum wage on the rise, and the hard work that it is. And in order to care for these people, I fear that we're going back to an institutionalized situation in a smaller setting in these group homes, where showers are only at 7 p.m. and people have to line up to take a shower because that's the only time that, you know, you have people there that can actually help them take

a shower.

So that is one question as far as the DSPs and your support in getting more funding, not only for cost-of-living but for wage enhancements, number one.

And number two is the dispensing of medication in the homes where there's a shortage of nurses. What is your recommendation to solve that problem within the group home?

OPWDD COMMISSIONER NEIFELD: So I guess I would start with your comment around, you know, the fear around slipping backwards to an institutional-like setting.

And I just, you know, want to stress on the record, right, that that is something this agency works against every day, in partnership with our providers and obviously people with developmental disabilities. It's the complete opposite of what this agency was founded to do, and what we fight against every day and drives us all.

And I know --

ASSEMBLYWOMAN GIGLIO: -- the DSPs,

the shortage of DSPs.

OPWDD COMMISSIONER NEIFELD: Absolutely. No, I understand. I just wanted to, you know, make that statement.

I think that, you know, I have already touched on sort of the cost-of-living adjustment, the rate rebasing. One thing that I want to talk about is -- a little bit more is the investment in the National Alliance for Direct Support Professionals, the microcredentialing, the work with SUNY, the work we're doing to invest in the professionalism of DSPs and how it is equipping them to feel more confident and better able to perform their duties. It does come with a stipend.

I mentioned the many bonus rounds that we have put forward as well. Every opportunity that we have to invest dollars into the DSPs, we are doing.

We're also launching, I referenced in my testimony, a very large media campaign, $30 million media campaign. It's not an OPWDD-branded campaign, it's for the benefit

of the voluntary providers as well, to really tell the story of what a DSP does, what does this work look like, how important these roles are, and direct traffic of people who are looking for jobs directly to our voluntary providers. That will be, you know, traditional media, social media. Everywhere people are out there talking about what they do, we'll be there. So we see the ads for OASAS as well, and we want to make sure that we're, you know, well represented.

Your question related to medication administration within certified settings. So within certified group homes, DSPs are able, under the supervision of a nurse, to administer medication. I don't think we -- we don't really experience a challenge with medication administration in our certified settings.

I do want to say we have the Article VII -- you know, the legislation that the Governor put forward to allow DSPs to do simple nursing tasks like medication administration in a non-certified setting --

in people's homes where they live independently, which we think is very important, and it is an equity issue for people with disabilities who could live independently but can't because there are not enough nurses to be able to come to their home once a day and administer medication.

It's important to allow a DSP to be able to do that so someone can live maximally independent.

ASSEMBLYWOMAN GIGLIO: Thank you. And then my next question would be educators for people with unique abilities. You know, the Department of Labor, I discussed with the commissioner last week about using the career opportunity centers for certain training programs in order to get people employed that are I/DD.

So have you spoken to the commissioner of Labor about that, and partnering and making sure that these career opportunity centers are being fully utilized not only for people on unemployment but for people with intellectual and developmental disabilities?

OPWDD COMMISSIONER NEIFELD: So just in the short time I have, the answer is yes, we work very closely with the Department of Labor, but we do very many other things, and we can make sure to share that with you in writing, what we do for people with developmental disabilities to find employment.

ASSEMBLYWOMAN GIGLIO: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

To the Senate.

SENATOR BROUK: Thank you.

Now we'll hear from Senator Weber, the ranker on the Committee on Disabilities.

SENATOR WEBER: Thank you, Madam Chair.

And thank you all, Commissioners, for being here today.

You know, I represent Rockland County, where we have a lot of direct service providers who are concerned, as mentioned earlier by my colleagues, with retaining and attracting staff. You know, it's very costly to live in the Lower Hudson Valley, and

they're really struggling to fill these positions.

And I've cosponsored, along with Senator Mannion's bill, the wage enhancement bill. I know you had mentioned, Commissioner, that you'll take a look at that. And I think it's something that really seriously needs to be looked at. You know, yes, the cost is expensive, right, $125 million by an estimate, but, you know, in Albany here we seem to throw billions around without even thinking collectively.

And, you know, I think this is -- this is -- I consider these workers essential workers providing essential services. Right? They do amazing work, and they're struggling and they're not able to provide all the services that they need to and could be able to provide if they were able to have these workers stay in their positions.

So I'm hopeful and thankful that you'll take a look at that and seriously consider it, because I consider it something extremely important. Again, the COLA

increases over the last number of years have been great but, again, it's nowhere near where it should be to provide these workers with a livable wage, especially in the areas where I represent.

So thank you for at least acknowledging to take a look at that as well.

I do have one specific question that I kind of wanted to focus on, so -- you know, individuals that use self-direction have to have their budgets approved by FIs, right? And the FIs that approve budgets are not approving requests for expenditures on community classes. And these classes are open to the public, but if individuals with developmental disabilities want to use their budgeting to pay for classes, these requests seem to be or are being denied.

Why should the developmentally disabled not be afforded the same freedom to choose the classes that would benefit them as their non-developmentally disabled counterparts? And, you know, if the family or the individuals feel that they will

benefit from these classes, why the pressure on the FIs to disallow these?

OPWDD COMMISSIONER NEIFELD: Thank you for the question. It's an area that we're spending a lot of time at the agency focusing on, and wanting to make sure that we're bringing a consistent understanding to all of our FIs.

First I want to say that we work with over 90 FIs across the state, so ensuring consistency, making sure that each FI hears the same message and is administering the program in the same way is a substantial effort, as you can imagine.

With regard to community classes, the whole premise of self-direction is for people to have choice. Right? They get to choose the services, what they pay for those services, how they access those services, but within parameters. It's not only state dollars that are involved in the self-direction program, there are also Medicaid dollars. Every Medicaid dollar that we spend in OPWDD is subject to an agreement

with the federal government, through our HCBS waiver.

So the parameters around community classes are very clear. They cannot be used where another Medicaid service could provide that, so it can't look like a day program. And it needs to be integrated and open to the community. So anybody in the community, you or I or anybody else who's interested in taking that class, must be able to. It must be open to all of us, marketed to all of us, not just to people with developmental disabilities.

There are some other small parameters, but within those parameters people have choice.

So what we're doing is, like I said, working really hard with FIs to make sure that there is consistent understanding. We're working to institute a process where families -- where FIs will have an appeal process. So if an individual who's self-directing, or a family, feels an FI made the wrong decision, they can bring an appeal.

That will be heard.

Also we're also going to be working with the FIs to create communities of practice across the state and regionally, so that they can be looking at these community classes, understanding what they're offering, and within the context of the parameters on the community class program.

But there has not been a change in the way we administer this program. And so what we're doing really is to make sure that there's consistent understanding.

SENATOR WEBER: Right. And I appreciate that. And I think having that consistency and understanding I think will go a long way in hopefully moving that forward. So thank you.

OPWDD COMMISSIONER NEIFELD: Thank you.

SENATOR WEBER: And I'll direct my questions at the next round.

CHAIRWOMAN WEINSTEIN: Thank you. We go to Assemblyman Ra, the ranker on Ways and Means.

ASSEMBLYMAN RA: Thank you.

Good morning, Commissioners.

So just starting with OPWDD and, you know, budget provisions, we've done COLAs the last couple of years. There's a proposal in this budget. One of the things myself and I know a lot of my colleagues get calls about in the aftermath of the budget is they hear about a COLA and then they wonder when they will actually see it.

So what's the status of the COLA we did in the last budget with regard to all the eligible workers having seen it? I would hope at this point -- and assuming that this COLA that is proposed in this budget goes forward, when would those workers be able to anticipate seeing it actually in their wages?

OPWDD COMMISSIONER NEIFELD: So the cost-of-living adjustment is something that adjusts the reimbursement rate for providers. It doesn't go directly to employees. Providers we encourage -- and I think all providers do invest some of the COLA in the wages. We don't obviously control when that

action happens.

The cost-of-living adjustment was received by the providers. It's retroactive to the effective date. So the 4 percent which you're referring to was seen by the providers in their reimbursement rates in September, but it went retroactive to April 1st. When the providers made adjustments to wages based on that 4 percent COLA, I can't speak to. That's an individual determination by each provider.

ASSEMBLYMAN RA: Thank you.

Regarding the Executive Budget proposal, which includes provisions related to substance use treatment and mental health treatment, including requiring the minimum reimbursement at the Medicaid rate for those services, and increasing penalties for insurers that don't comply with federal parity laws, are these proposals related to the data gathered from the reports that we require under the Insurance Law?

OMH COMMISSIONER SULLIVAN: The data was worked on with the Department of

Financial Services, so I can't say if it's exactly from the Insurance Law, but the data has been confirmed with the Department of Financial Services.

ASSEMBLYMAN RA: Okay. And regarding -- in last year's budget, in the Health and Mental Hygiene budget, we included provisions enacting behavioral health insurance reforms, including reimbursement for school-based mental health clinics, removing prior authorization for opioid antagonists, and creating a provider network access standard.

How do those proposals from last year relate to this year's proposals around substance use treatment and mental health treatment parity?

OMH COMMISSIONER SULLIVAN: Last year the funding was specific for school-based. What is being proposed this year is that any mental health or substance use service in one of our licensed clinics, that the commercial payers would pay for any of those services at the Medicaid rate. So it's a large -- it's

an expansion. Last year was just for the school-based clinics.

ASSEMBLYMAN RA: Okay. And can you provide any insight on how that has worked, what we did last year in the budget and the implementation of that?

OMH COMMISSIONER SULLIVAN: It became effective January 1st in terms of the increased commercial rates. And so we're in the process of working very, very closely -- there are some snags, but everybody's working very hard to make sure that the money flows the way it should.

ASSEMBLYMAN RA: Okay. And one other thing for the Office of Mental Health. You know, we have a proposed 4 percent increase on the Joseph P. Dwyer Program. How is it determined how that is disbursed to the counties around the state?

OMH COMMISSIONER SULLIVAN: Every county has a Joseph Dwyer program. It's disbursed pretty much on the population of veterans in those areas.

Now, some Joseph P. Dwyer programs

existed already; others are startups. So some of the startup ones got a little more money to start the program. But it's really based on the population of veterans that they serve.

ASSEMBLYMAN RA: Thank you.

SENATOR BROUK: Okay, next up we will have Senator Salazar.

SENATOR SALAZAR: Thank you.

And thank you for your testimony.

For Dr. Sullivan, my office has frequent correspondence with incarcerated individuals in DOCCS prisons across the state. We often hear and see, in visiting facilities as well, incarcerated individuals not getting sufficient access to mental health care while in prison, especially if they are sent to the Special Housing Unit.

And I understand, through speaking with OMH providers during facility visits, that OMH staffing levels in prisons is currently a serious challenge for providing adequate care.

How is OMH -- or this budget --

assuring that incarcerated individuals on OMH caseloads are receiving the care that they need, especially in moments of mental health crisis or upon requesting that care while they're incarcerated?

OMH COMMISSIONER SULLIVAN: Yeah, this is monitored, you know, very closely. And all the assessments that are needed in terms of the solitary confinement and the RRUs, et cetera, all those assessments are being done. And we've been able to recruit enough staff to make sure that the assessments on the call-outs for individual therapy, that those are all done.

The one thing that has been affected is our ability to do some of the group programming because of the shortage of staff. So we clearly prioritize.

One of the things we're working on is to see how much of the programming could be done by tele in some way. And if we can work that out with some of the prisons, depending, that might be able to expand that in terms of the workforce.

We already do, in terms of treatment, a lot of telehealth in the prison system, both psychiatrists, social workers, et cetera -- again, because of some of the more remote prisons needing that assistance. So we work very hard to recruit. All the absolutely necessary assessments are things we have been able to recruit for and make sure that they get done.

SENATOR SALAZAR: Thank you.

And, you know, it's encouraging to see -- first of all, it's encouraging to hear that, but additionally to see the Executive Budget's about $24 million investment, partly in criminal justice system-related initiatives. Will any of that funding go specifically to improving the mental health care or programming for individuals who are currently incarcerated, not only -- even though it's very important -- folks in transitional housing or after release?

OMH COMMISSIONER SULLIVAN: That funding is specifically for individuals who

are either leaving the prisons or to prevent them from getting into the prisons. So that particular bucket of funding is not going directly to the prison services.

SENATOR SALAZAR: Got it. Thank you.

OMH COMMISSIONER SULLIVAN: Thank you.

CHAIRWOMAN WEINSTEIN: We go to the ranker on the Mental Health Committee, Assemblyman Gandolfo.

ASSEMBLYMAN GANDOLFO: Thank you, Chair Weinstein, and thank you all for your testimony today.

My questions are going to be directed at you, Dr. Sullivan, regarding the mental health clinics in schools initiative here.

Now, I know we've spoken a little bit about -- it's startup money. Now, with schools applying to try to put in their own mental health clinic, would they have to demonstrate any further financial means to operate it and keep up with the capital costs?

OMH COMMISSIONER SULLIVAN: No. Basically the -- we have somewhat increased

rates, so it's $25,000 for schools that are financially in very good shape, and $45,000 for startups. So all the schools would have to do is tell us that they're more in the distressed range to get the 45,000.

It's a partnership with community-based providers, so there really is very little capital cost. It's a certain amount -- it's just a certain amount of space. And then the provider does all the billing, all that work for the school.

The increased rate also enables the school-based provider to do a little more counseling with teachers, a little more work with parents, things that are not exactly billable all the time. So I think in overall they will be able to apply, as I said before, on a rotating basis. So any school can call us or call their local provider, and we will help set up a school-based clinic.

ASSEMBLYMAN GANDOLFO: Okay. And I guess I should have led with this. What would constitute a clinic on a school? It would be staffed with a social worker and a

psychologist? What exactly would --

OMH COMMISSIONER SULLIVAN: It's usually staffed by a licensed professional, so it could be either a social worker or a psychologist. Depending upon the need in the school, it could be they're one day a week, it could be they're three days a week. Those things are determined between the provider and the need and size of the school.

ASSEMBLYMAN GANDOLFO: Okay. And what about ongoing costs of keeping it staffed itself? I know some of my school districts -- one actually just opened what they call a wellness center. It came out great. It's a little break room for the kids that has a social worker and a psychologist staffed there. They're a little worried, with some of the school aid numbers that come out, that they won't be able to continue to provide the service and keep those offices staffed.

Is there any plan in the future to open a pot of funding so that they can actually hire the people and keep them there?

OMH COMMISSIONER SULLIVAN: A critical piece is the reimbursement, so two things were done. One is the Medicaid rate was increased. And then, number two, commercial payers -- and this was an issue -- commercial payers were not paying for school-based services.

So in last year's budget it was mandated that they had to pay for school-based services. So between the increased Medicaid rate and the fact that the commercial payers have to pay the increased Medicaid rate, that makes basically the services that are provided financially viable.

ASSEMBLYMAN GANDOLFO: Okay, great, thank you.

And just moving on a little bit, I know last year we announced the big $1 billion investment in mental health. I know it's a multiyear investment. Over the first year, are there any data points showing any movement or any improvement in certain areas? Can you talk about that a little bit?

OMH COMMISSIONER SULLIVAN: First of all, the money is -- I just want to say the money is out. So basically by April 1st the 42 requests for proposals, which involved all that funding, will be out before the end of this budget year. We have 34 of them already out.

In terms of outcomes, it takes a little time to see the outcomes. But something which started early and then was enhanced was the Safe Option Support Teams in New York City, in the subways, in terms of housing homeless individuals.

And just one critical outcome of that, so far 300 individuals have been placed in permanent housing and are staying in permanent housing. And these are individuals who often had spent years in the subways in New York City. That program is being expanded across the state.

So in all the programs we're really looking at financial but also clinical outcomes, and we will expand them based on the basis of those clinical outcomes. But

all these new dollars have clinical outcomes associated with them.

ASSEMBLYMAN GANDOLFO: All right, great. I think that's all I have, so thank you all for your time.

CHAIRWOMAN WEINSTEIN: Thank you.

To the Senate.

SENATOR BROUK: Thank you.

We'll now hear from my partner in the Mental Health Committee, Ranking Member Canzoneri-Fitzpatrick.

SENATOR CANZONERI-FITZPATRICK: Thank you, Chair.

Thank you, everybody, for being here today.

I have a lot of questions that of course can't be answered in five minutes, but I do want to thank you for what you're doing. We've heard testimony today from other members of the Legislature regarding the concern over the COLA increase and how it's not quite going to do what we want it to, in the sense that DSPs are so valued for taking care of our most vulnerable population, and I

do have concerns over the fact that minimum wage is outpowering the wages that we're paying our DSPs.

So I thank you for pushing for correcting that.

The 20 percent vacancy rate has been mentioned today. And our annual turnover, I've heard, is about a third. And I wonder if failing to increase our COLA increase, the failure to keep up with inflation, is going to address that issue sufficiently.

However, I would like to ask some questions more focused on the school-based mental health clinics. I believe the testimony was that 1200 school-based mental health clinics will be started, there will be startup funds associated, allocated to these clinics.

My question, though, is do schools have to apply to have this mental health clinic established? And if they don't apply, does that mean that they get no mental health assistance?

OMH COMMISSIONER SULLIVAN: There's

1200 that actually exist. So we have 1200 now, and we're planning on increasing that number.

The school has to work with us. So basically we are talking to the schools. I personally talked with all the district superintendents. We want them to come to us. We also have our providers talking with the schools. So it has to be a partnership. The schools have to work with us, but we're doing a lot of outreach to the schools. Most of the schools are very interested, they just are very busy. But we are working with them, and we're getting this done.

So we're expecting another 200 we could hopefully open this year, and then keep a rolling phenomenon and keep opening them over time. Once open, they stay open and they do a lot of very good work. But it will be a rolling application, so a school can come to us any time of the year and we will work with them. Or we are also going to schools.

SENATOR CANZONERI-FITZPATRICK: Okay.

And as was stated by my colleagues, the funding going forward in the future will have to be there to maintain these clinics because if you're just giving them startup costs, that will have to be something that we continue to focus on.

I believe, Dr. Sullivan, your statement -- your testimony that there was a budget proposal -- the budget proposes legislation to control the addictive algorithms aimed at youth and increased parental controls over social media access.

And in a world where cyberbullying is increasing, depression and anxiety is fueled by social media, and as the mom of three girls -- and of course I had my son too, but I do feel that women are more susceptible, young teenage women are horribly susceptible to the depression and anxiety that is fueled by social media.

So my question specifically is, are we doing enough to address this crisis? And what more would you suggest that we do as a legislative body to address this crisis? I'm

not sure about what specific legislation you were referring to, Dr. Sullivan, so I'd like to hear your thoughts.

OMH COMMISSIONER SULLIVAN: Yeah, the legislation does a couple of things. It gives increased parental control over the time youth are on social media, the ability to oversee any kind of consent for what youth are seeing and what they see, and also prohibits the use of these -- I'm not the tech person, but these algorithms that just keep coming and pushing certain information.

So I think it really is a very strong beginning of dealing with the problems.

The other thing which we will be doing is developing guides for parents and for youth about social media with the schools. So it's a joint effort also to educate parents on how to use it. So there's the legislation and then the education. And I think it's beginning -- the surgeon general report really pointed out how serious this issue is. But this I think is a very strong beginning to get some control over the issue

with the social media.

SENATOR CANZONERI-FITZPATRICK: Thank you.

And I only have a short period of time left, but one of the things that I wanted to know if it's been considered is other states have had success with deeming a person that shows up at a hospital from an overdose as a mental health crisis that needs addressing, possibly hospitalization and assistance.

And I'm wondering if you've examined what has been happening in other states and if there's a possibility we could consider that in New York. And I realize I'm out of time, but I hope you'll consider that.

OASAS COMMISSIONER CUNNINGHAM: Absolutely.

SENATOR CANZONERI-FITZPATRICK: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblyman Epstein, three minutes.

ASSEMBLYMAN EPSTEIN: Thank you, Chair.

And thank you all for taking the time to be with us today.

Dr. Sullivan, just on the mentoring program, are you working with the New York State Mentoring Department, there's a state agency that focuses on mentoring in New York State?

OMH COMMISSIONER SULLIVAN: We've been doing some work, I think, but I'm not as familiar with it as I would like to be.

ASSEMBLYMAN EPSTEIN: I'm a little worried that we have a full state agency that's set up to do mentoring around the state, and there's lack of coordination. Like everyone lives in their own bubble, and the reality is then no one knows what anyone else is doing.

And, you know, there's a lot -- it's really important that we coordinate and work together so -- and so we can then comprehensively provide resources to mentoring in a much more comprehensive way.

OMH COMMISSIONER SULLIVAN: It would definitely work on that, thank you. That's a

great suggestion.

ASSEMBLYMAN EPSTEIN: I appreciate that.

And last year we talked a lot about the issues around mental health issues in higher education and that each campus was really on their own, not getting support from OMH. I'm wondering what you've done over the last year to kind of support those campuses, provide written guidance to them. We'd asked for follow-up but I hadn't gotten any of that for my office.

OMH COMMISSIONER SULLIVAN: We've been working very closely with SUNY, and at this point in time in terms of 988 and spreading that across the SUNY system.

We also have a resource directory that's on the website for all the SUNY colleges of where there's mental health services nearby.

And we are doing a lot of mental health first aid, both for the teachers and for the students across the SUNY system. Now we're going to be expanding that to the other

college systems. But we've started with SUNY.

We're also --

ASSEMBLYMAN EPSTEIN: So it would be great to share that with us, because we'd love to be able to add it to our schools, some of our CUNYs and private colleges as well. If there's a way that your staff could direct us to where on the website it is, that would be really helpful.

OMH COMMISSIONER SULLIVAN: Yes.

ASSEMBLYMAN EPSTEIN: I wanted to -- just to focus on -- Commissioner Neifeld, I just wanted to focus on intake and kind of where the intake process is. You know, we've heard a lot from people who are going through the system but the complications of getting the services that they need -- we've talked about better coordination and effort. I'm wondering where things are in relationship to that.

OPWDD COMMISSIONER NEIFELD: Sure. We have a pretty detailed -- on our website, and certainly, you know, through our care

coordination, for how families can access our system for the first time. It's called the Front Door.

One thing we just did actually was posted on our website new videos that really are tutorials for families on how to go through the Front Door process, working with their care coordination organization and with OPWDD. It's also in Spanish and in Mandarin. So we're excited about that.

So I know we're -- there's not a lot of time to walk you through that, but I think, you know, our program is intentionally -- I wouldn't say hard to access, but our program is intentionally accessed through assessments, through, you know, making sure people are eligible for a reason.

ASSEMBLYMAN EPSTEIN: I'll look at that, and maybe I'll follow up with your staff.

And Dr. Sullivan, one more question about beds online for long-term mental health beds. We've heard that there's -- you know,

we're allocating more money in the budget. Are those beds online? If not, kind of when is the timeline to get those beds online?

OMH COMMISSIONER SULLIVAN: All the 150 state hospital beds from last year -- state hospital beds are open.

The 200 additional beds this year, we're hoping to open approximately 75 of those this year, and then the rest the following year.

CHAIRWOMAN WEINSTEIN: Thank you.

Senate?

SENATOR BROUK: Thank you.

Before our next question, I just want to recognize Senator Scarcella-Spanton has joined us. Welcome.

And next for questioning, Senator Webb.

SENATOR WEBB: Thank you, Commissioners, for being here.

So I just have two questions due to the amount of time. I know we've been talking a lot about COLA, and I recently connected with one of the providers in my

district -- in Cortland, specifically -- and they're down 35 percent for DSPs. And I know that, you know, advocates are seeking -- we are as well -- a modest 3.2 percent COLA, as well as a guaranteed COLA. I mean, we talked about this last year as well.

And so my question to all of you is, do you believe a 1.5 percent COLA is adequate to address the workforce issues that providers face in trying to hire and retain staff? So that's one question.

And then my second question deals specifically with challenges we're seeing around overdoses. So I know that the amount of overdoses we've been seeing just in the last four years have beyond quadrupled as it pertains to specifically fentanyl overdose deaths.

And so I was hoping that you can expand upon why do you believe these overdoses have increased at such alarming rates? And what's the plan to stop that trend?

OPWDD COMMISSIONER NEIFELD: I can go

first on the workforce.

I guess I would just sort of emphasize what I said in my testimony, that I don't believe that there is a single solution to affecting the workforce crisis. I think, through the things that I talked about -- the cost-of-living adjustment this year but also the previous two years, the rebasing that we're doing on our rates, the media campaign, the microcredentialing and credentialing and stipends and bonuses that we're providing to staff and to our voluntary sector -- all of that in totality I believe, I believe that we are doing everything that we can as an agency to impact the workforce crisis.

OASAS COMMISSIONER CUNNINGHAM: In terms of overdose deaths, I mean, what you described is definitely what's happening across the state and what's happening across this country.

Really a lot of the reason for this is because of the toxic drug supply. So we know that fentanyl is really driving overdose deaths, xylazine is also contributing, and

who knows what's next? What we're really focusing on is, you know, evidence-based harm reduction efforts and expanding treatment.

So in terms of harm reduction, expanding naloxone kits and other tools like fentanyl test strips and xylazine test strips so that people can then detect what's in their substance if they're going to use a substance and then change their behaviors accordingly.

And then also our focus is on expanding access to evidence-based treatment, which we know reduces the risk of overdose by 50 percent, particularly methadone and buprenorphine, and really taking these services and bringing them to the communities that are at the highest risk. So that includes mobile medication units, bringing methadone treatment to communities that don't have a brick-and-mortar opioid treatment program. Funding low-threshold buprenorphine treatments so people can get same-day access to medication.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblyman Eachus, three minutes.

ASSEMBLYMAN EACHUS: Thank you, Chair.

Commissioner Cunningham, I'd like to take a look at this "requires medication treatment for all substance use disorders in carceral settings." On May 6, 2023, in my local county jail, a young woman was found dead in her cell. It's listed as unknown causes, but she was a known drug addict and she was showing signs of withdrawal.

So I am suggesting that we have a lot more work to do. We can't allow these folks to lose their lives because of the lack of learning and so on like that, so.

Commissioner Neifeld, I'm interested in your "Look Beyond My Developmental Disability." Everybody should be aware we cannot see through the lenses of these disabled folks, so we need them to show us exactly what's needed to overcome the difficulties that they have out in society.

I have not seen this program, and yet I would consider this body right here as one

of the most important bodies to be seeing this program. So as it gets developed further and further, I hope you bring it to all of us so that we can understand what the difficulties are for those out there.

OPWDD COMMISSIONER NEIFELD: Happy to.

ASSEMBLYMAN EACHUS: And then the final thing actually goes back to last year's question, between OMH and OPWDD. I talked about both departments being very siloed, from my own personal experience. But yet today I heard about cross-programs, programs that the two of you are working together with.

It is my hope that you will present my office with those programs and where you are with those programs and maybe I can assist you in some way in continuing to develop those.

I would say the final thing I have is, Commissioner Sullivan, thank you very much for your responses. I'm looking forward to working with you. A couple of the issues brought up today you and I are going to take

a look at. And I would like you to just let the rest of my colleagues know that we can work along with you to solve some of these problems, whether they're in-school clinics or, in my particular case, a closed hospital.

So thank you.

OMH COMMISSIONER SULLIVAN: Thank you.

OPWDD COMMISSIONER NEIFELD: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

To the Senate.

SENATOR BROUK: Thank you. We'll hear from Senator Scarcella-Spanton.

SENATOR SCARCELLA-SPANTON: Thank you so much.

And thank you for your testimony today.

I have three questions. My first would be we're getting a lot of reports from our local organizations that those cost-of-living adjustments that were meant for wages are not going to the wages of the DSPs. So that's been an issue that's been brought up to us several times.

Another issue that I'd like to bring up is the pay differential for OPWDD. Employed direct support professionals have seen increases in their starting pay, which is now at about $27 -- 27 in New York City and 25 for the rest of the state -- while at the same time the starting pay for a DSP providing similar services at a nonprofit is significantly lower at $17 an hour. So we have a workforce that tends to be leaving or moving over.

And lastly, I just wanted to say any ways that we can work together on the fentanyl and xylazine issues that we've seen coming up, I want to be a partner. I actually got news that a friend of mine -- this is now the 11th person I know on Staten Island who has overdosed, just this morning.

So any ways that we can work together to bring this to schools, please utilize us as a partner. But thank you.

OPWDD COMMISSIONER NEIFELD: On the cost-of-living adjustment, I just wanted to

emphasize the cost-of-living adjustment is an enhancement to the rate of the provider. We do not supply the cost-of-living adjustment directly to DSPs. The legislation does not require that it go only to the salary of DSPs. It emphasizes the importance of making that available to personnel.

And we do collect an attestation from our providers to understand how they use that. But the money goes directly to providers, and it is up to providers how and when they program those additional dollars and when they go to staff.

So if there are individual concerns, I think that's related more to the provider than it is necessarily to OPWDD.

And, you know, appreciate your comments on the cost-of-living adjustment and its -- whether or not it's enough to impact the salaries. I think I've said -- and I don't want to take the time away from Chinazo, Dr. Cunningham -- you know, we are investing I think with the resources that we have as an agency in every possible way we

can to support our workforce.

SENATOR SCARCELLA-SPANTON: Thank you.

OASAS COMMISSIONER CUNNINGHAM: In terms of the drug supply, so, you know, exactly what you're talking about is the reason why we did a very successful public awareness campaign, informing the community about fentanyl and the risks of fentanyl, and then also directing them to our online portal, where people can access naloxone, fentanyl test strips and xylazine test strips for free. It takes about 30 seconds to do that.

And we've shipped out over 70,000 naloxone kits, 5 million fentanyl test strips, and 4 million xylazine test strips.

So we'll continue to work with, you know, whatever partner in the community to make sure that they have expansion of those lifesaving tools.

SENATOR SCARCELLA-SPANTON: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you. So we go to Assemblymember Chandler-Waterman.

ASSEMBLYWOMAN CHANDLER-WATERMAN:

Thank you so much, Chair.

Thank you, Commissioners, for your time today.

I appreciate the support, Commissioner Sullivan, for the Assembly District 58 Mental Health Task Force, a working group I created since taking office, comprised of individuals with lived experiences. They set the priorities for my office in District 58 and in Brooklyn for us.

So we believe peer advocates and family support must be an intentional part of the conversation, programs, facilities. And of course, Commissioner Cunningham, we're going to be doing some work together as well.

In the Executive Budget, right, they talk a lot about beds. That's a crisis response. Not that we don't need beds, but we need early intervention, which is the best way to promote emotional wellness and reduce rates of hospitalization. Many of these hospital settings, as you know, re-traumatize individuals seeking care. And one solution for early intervention, as we discussed

before, is respite centers and clubhouses, which are peer-run residences that provide therapeutic, person-centered, trauma-informed and culturally responsive care for our community members who are unwell, and thus get a sense of, you know, belonging and that they're validated and heard.

It's important that we invest more into that, the local community-based, culturally responsive respite centers, clubhouses. We don't necessarily want to travel so far out of our district to get those services. Not just about the beds.

But now we have to talk about hospitalization. So when we have co-occurring disorders we need to destigmatize and decriminalize, as we all know, when it comes to mental health and substance use and abuse. And it starts with the agencies really working together collaboratively, especially with allotment of beds for co-occurring disorders.

And also after-care referrals. When individuals leave a behavioral health

facility, they need more support when they're having issues where they need to go to another facility. And sometimes the stigma is on coming from a behavioral health facility and now, when it comes to substance use and abuse, they're necessarily not taking them directly from the hospitals to a program or having their co-occurring, you know, issues being dealt with there. They have to come out, they relapse, and then they are -- it's easier for them to go in to deal with the substance use and abuse. As we know, mental health -- they both go together.

And then the family support. It's the best way for recovery, right? So what is in place now when you enter from CPEP, with the family members -- here's the number to reach out to your family member. Here's the after-care plan. How do we intentionally put our family in support with that?

I know there's not a lot of time --

OMH COMMISSIONER SULLIVAN: No.

I think on the family work, yes, exactly, that's what happens. And we want

both the hospitals but also the community behavioral health centers, everyone to engage families, work with families, do that outreach to families that are a critical, critical piece of anybody's recovery, of anybody getting better. And I think there's a lot of training going on to improve that across the system.

The other pieces that you've brought up I think are further -- we'll talk.

CHAIRWOMAN WEINSTEIN: You'll have to send us answers, as well as some of the others, along to the committee chairs.

And we go to the Senate now.

SENATOR BROUK: Great. Next up, Senator Rolison.

SENATOR ROLISON: Thank you, Madam Chair.

Dr. Sullivan, we talked in last year's budget hearing about bringing additional beds online within the public hospitals and also state facilities as well. On the public side -- and you said you've added beds. What do you think -- what was that number? And if

I missed it, I apologize.

OMH COMMISSIONER SULLIVAN: On the state side, we added 150 beds last year. And in this budget there will be 200 beds on the state side. In the community, 500 beds were opened this year that had been offline due to the pandemic.

SENATOR ROLISON: How were those beds chosen? In what location, geographically, throughout the state.

OMH COMMISSIONER SULLIVAN: On the state side, we're looking at a combination of need, where they are needed. And also, to be honest, the construction, what we have in buildings in various state facilities. So it's a combination of what can be easily and quickly renovated, but also where the need is across the state.

SENATOR ROLISON: Dr. Cunningham, I'm glad that you had spoken in your testimony about the -- obviously the use of cannabis as it relates to youth and young adults. And you're talking about, you know, providing evidence-based training and getting that

data.

When do you think that you'll have data to show what that looks like?

OASAS COMMISSIONER CUNNINGHAM: We have data most recently from, I think, 2020 or 2021 -- so this was before the adult use dispensaries opened. Which actually shows no change in use among young people. But we do know that their perception of risk is that they don't perceive cannabis to have much risk.

But we're closely following this. We're doing surveys in schools and among young adults so that we're well-positioned to address this issue.

SENATOR ROLISON: And when we talk about providers, training providers, you know, what does that look like? Who is that in community-based health?

OASAS COMMISSIONER CUNNINGHAM: So those are our outpatient clinics that are serving anybody with any substance use disorder, making sure that they know that cognitive behavioral therapy, motivational

interviewing are really evidence-based treatments for cannabis use disorder.

SENATOR ROLISON: And one of my colleagues before talked about marijuana, cannabis, and how it is impacting adults as well with, you know, ER visits, et cetera, you know, based on whatever they may be using.

How is your workforce kind of put together for this emerging problem? I mean, is it something that you need to think about workforce-wise?

OASAS COMMISSIONER CUNNINGHAM: Absolutely. So, you know, as part of our training for our professionals in addiction, certainly cannabis is part of that training. And we're continuing to update our curriculum for training to reflect the changes in the cannabis industry.

SENATOR ROLISON: Good. Thank you.

Thank you to the three of you for being here today.

CHAIRWOMAN WEINSTEIN: Thank you. To the Senate -- oh, no, to the Assembly.

You're sitting on -- Senator Rolison, you're sitting on the Assembly side. I got confused for a moment.

We go to Assemblywoman Walsh.

ASSEMBLYWOMAN WALSH: Thank you very much, Chairwoman.

Good morning. So as we sit and we look at the large budget numbers that are being, you know, discussed in today's hearing, I just really wanted to put a more human touch on it and to give you an idea of the kind of people that I hear from on a regular basis.

I received this email yesterday. This is from a mother of a 12-year-old boy who has fetal alcohol syndrome, a history of PTSD, ADHD, low IQ, and reactive attachment disorder, who was adopted by the parents: "I've been going round and round with the mental health system, the school district, DSS and OPWDD for the last two and a half years. My son has been in and out of the hospital ERs. He has a developmental disability and mental health issues, and we

are stuck in no man's land for getting him the help he needs.

"OPWDD doesn't have housing for kids of his age, 12 years old. OMH won't touch him because he has a developmental disability. Which doesn't make sense because you can have both a developmental disability and mental health issues. Also, 90 percent of people with fetal alcohol syndrome have mental health comorbidities.

"The school won't help because he can be good at school with his one-on-one aide, and DSS says that they would charge me with neglect and take my other kids because I'm an unfit mother."

It goes on. She includes all of his visits to the hospital ERs. She says she's stuck in a situation where no one seems to be able to help him get a residential placement for more intensive help. She goes on even further.

And then, at the end, she just says: "I'm begging for help. I don't know where to go."

We all, we all get calls and letters like this, and emails. And the desperation from some parents who find themselves in these situations is one of the most heartbreaking things that I know I have to do and work on as a member.

Could you -- I know you talked a little bit about Front Door. Could you just address -- tell a parent like this what we've got in place or if there's anything in this budget that's going to help resolve these really heartbreaking situations that we find ourselves hearing about.

OPWDD COMMISSIONER NEIFELD: Sure. thank you. And I will ask to follow up so that we can make sure we get the contact information and reach directly out to that family.

You know, there are a lot of things that we are doing across the agencies. I think other partners that are really critically important to this conversation are the Department of Health, State Education Department, OCFS. We're working all the time

to try to continue to build new resources.

I will say that OPWDD does have residential opportunities for youth. We make sure that we work very closely with the school districts so that an individual's right to an education is preserved when we're looking at these residential opportunities. They're all across the state, residential schools. You know, there are -- obviously I don't know the circumstances here.

But it is a misconception that young children do not have access to residential opportunities. Dr. Sullivan talked about the SUNY Upstate program that we're building. I talked about the program in the Mid-Hudson Valley. These are meant to be short-term interventions with the focus on returning home. That's obviously where we like to start.

But -- I know I'm running out of time, but we will absolutely work on this specific case.

ASSEMBLYWOMAN WALSH: We'll be glad to work together. Thank you.

SENATOR BROUK: Thank you.

Next we will have our Finance ranker, Senator O'Mara.

SENATOR O'MARA: Thank you.

Good afternoon. Thanks for being with us today.

I just want to follow up again on the -- not that we haven't talked about it quite a bit already, the direct support providers and the wages there.

I really think strongly that more needs to be done. I think that the impacts of the increasing minimum wage over the years has had an impact on that workforce, particularly when the fast food wage first kicked in at $15 an hour, a huge increase.

You know, I'm seeing, throughout the district I represent, group homes closing. And closing not because of the lack of I/DD clients; it's the lack of DSPs to provide for them.

Now, according to my calculations on the last three years of COLAs for direct-support providers, it's a cumulative

about 11.3 percent increase. But during that period, minimum wage has increased about 13.6 percent and inflation over that three-year period has been about 12.5 percent.

So we seem to be, based on my calculations, losing ground in this battle when we're trying to make up and make this type of work more desirable from a wage standpoint than working in a fast food restaurant or some other certainly less meaningful work for society.

So what are your thoughts on losing ground to an ever-increasing minimum wage, and that's exacerbating, I think, the workforce for DSPs.

OPWDD COMMISSIONER NEIFELD: I would just add that in addition to the cost-of-living adjustments in this budget and in the previous two budgets, there are also adjustments for minimum wage to help the agencies keep pace with minimum wage.

I referenced our work this year to rebase our rates so that they are more

reflective of current costs. But I -- I mean, I certainly understand your concerns. We recognize the incredible work that DSPs do. We agree that DSPs are doing work that is -- you know, that should be valued well above minimum wage and is certainly more challenging and more meaningful than some of the other, you know, jobs that we see that are paying the same rate.

I think that, as I've said, within the resources we have, and this agency's budget, we are doing everything that we can to invest in our DSPs -- and, like I said, not just in the wage area. Credentialing, marketing, everything that we can to continue to bolster this profession.

SENATOR O'MARA: Thank you. I think it's critical that we pay more attention to that. You know, these are individuals in need, they need these living settings. Families need them for their loved ones. So I really think we need to concentrate and focus more on being able to make it a more desirable job for individuals to take.

So your continued attention to that is appreciated.

OPWDD COMMISSIONER NEIFELD: Thank you.

SENATOR O'MARA: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblyman Bores.

ASSEMBLYMAN BORES: Thank you.

Thank you all for being here.

All of you have mentioned workforce shortages. Obviously we've talked about that a lot. Without getting in trouble or pushing any more, would a higher COLA help you recruit and retain more people in this profession?

(No response.)

OPWDD COMMISSIONER NEIFELD: Can I just --

ASSEMBLYMAN BORES: It's okay. Can the court reporter note that everyone smiled.

(Laughter.)

ASSEMBLYMAN BORES: Dr. Cunningham, you mentioned your new programs promoting responsible gaming.

There's a push afoot to expand mobile gaming to all table games through your phone. Would that lead to more or fewer cases of problematic gaming?

OASAS COMMISSIONER CUNNINGHAM: Yeah, I mean, we -- you know, we are closely monitoring what's happening in terms of behaviors with gambling.

We do see a modest increase in the number of calls that are coming into our helpline, and the number of treatment -- people seeking treatment.

So, you know, we're ensuring that the dollars that we have are going towards prevention, towards harm-reduction efforts and to make sure that evidence-based treatment is available. So we're positioning ourselves to be able to respond.

ASSEMBLYMAN BORES: Wonderful. Thank you.

There's a lot in testimony about court interventions, mental health courts, county courts. Do any of these sorts of interventions also apply to people who are

convicted or are charged with felonies?

OMH COMMISSIONER SULLIVAN: Yes. Yes.

ASSEMBLYMAN BORES: Yes?

OMH COMMISSIONER SULLIVAN: Yes.

ASSEMBLYMAN BORES: Are there mental health courts that address people who have been charged with felonies?

OMH COMMISSIONER SULLIVAN: It depends on the decision of the prosecutor, whether or not that could go to a mental health court. But yes, they do deal with felonies.

ASSEMBLYMAN BORES: Wonderful.

There's testimony from a later panel that's quoting the Unified Court System from October 2023 saying that the vast majority of people in our -- who are incarcerated are suffering from mental illness, substance abuse or co-occurring disorders.

So the more we can address that through mental health courts and other bits that actually help to solve the problem -- not only does it solve the program, but we'll save the state a lot of money in the long term.

And then, lastly, Commissioner Cunningham, I see 9 million, I think, going to contingency management initiatives here. Would love to just hear you talk a little bit more about, you know, what your hope is for that program and where we can expand it.

OASAS COMMISSIONER CUNNINGHAM: Yeah, I mean, we know contingency management is important, particularly for stimulant use. And we know that stimulant use is certainly on the rise in terms of its contribution to overdose deaths.

So, you know, we are exploring options using contingency management as a treatment approach. A lot of the challenge has to do with implementation in the real world outside of research settings. But that is something we're continuing to explore with our programs.

ASSEMBLYMAN BORES: Thank you.

SENATOR BROUK: Okay, back to the Senate. We'll have our second round for Chair Senator Fernandez.

SENATOR FERNANDEZ: Thank you.

We know that the Governor has proposed exempting certain populations from PMP and I-STOP, including those who are incarcerated, to help facilitate treatment. And you, Commissioner Cunningham, stated that the services are available in every correctional facility, jail and prison. But as we heard from other testimony, there are still some issues to be worked out.

This is a good start, but we're also hearing from providers on the ground that the implementation has been unequal and many jails are out of compliance, whether that's to willful noncompliance or real issues, as in transportation, going to get the medicine.

What information is being collected from sheriffs to ensure -- and anyone else, really -- to ensure compliance among correctional facilities? And what is being done to correct noncompliance?

OASAS COMMISSIONER CUNNINGHAM: Yes, so we are working very closely with all 58, you know, jails and the 44 prisons to ensure compliance. And as of now, all of the

carceral settings are in compliance.

You know, it has taken a lot of work, particularly with methadone treatments. We're working very closely with our opioid treatment programs to partner and provide the treatment in carceral settings.

We also work with DOCCS and SCOC together as -- you know, we don't have the authority in the carceral settings, but we work with them, we do site visits, you know, we investigate complaints from people who are incarcerated to ensure that -- that compliance is happening.

SENATOR FERNANDEZ: Okay. I would encourage more looking into that, given the testimony that we did hear.

Naloxone and Narcan that we have available, if you could share I guess OASAS's position and thoughts about increasing dosages, making available other dosage sizes.

We know that Narcan, the brand that the state has contracted with, only allows 4 milligrams, but there's thoughts and conversations to increase it to 8. What are

your thoughts on that?

OASAS COMMISSIONER CUNNINGHAM: Yeah, there is an expansion of reversal medications. It's naloxone, but the 4 and 8 milligram dose. There's also now nalmefene, another medication. I think this is good for the field.

What we do know from a State Department of Health study that was just released last week is that the 4 milligram dose is basically equivalent to the 8 milligram dose, but there's actually more side effects with the 8 milligram dose in terms of withdrawal.

So I think right now it's -- certainly the gold standard continues to be the 4 milligram dose of naloxone, where we have the most data that supports that.

SENATOR FERNANDEZ: Thank you so much.

And could you expand a little more about the I-STOP exemption? I have 20 seconds, but -- why that this proposal is needed.

OASAS COMMISSIONER CUNNINGHAM: So

I-STOP and the PDMP really is about the pharmacy dispensing medication. So for example, methadone that's administered in opioid treatment programs is not considered in I-STOP because it does not go through a pharmacy for distribution.

SENATOR FERNANDEZ: Okay, thank you.

CHAIRWOMAN WEINSTEIN: Assemblywoman Gallagher.

ASSEMBLYWOMAN GALLAGHER: Hi. I'm Assemblymember Emily Gallagher, from District 50, and I am also a big proponent of harm reduction. So I have a couple of questions about the harm reduction programs that you're running, Dr. Cunningham.

I am curious about what's going on with the AIDS Institute Office of Drug User Health Hubs. I understand that there's $256,690,000 available when you look at all of the Opioid Settlement money and the different funding streams, but it's my understanding that OASAS has not been funding the Drug User Health Hubs through allocation.

Is that true?

OASAS COMMISSIONER CUNNINGHAM: So through the Opioid Settlement funds the State Department of Health has received $35 million in fiscal year '23 and in '24. And then they decide how they're going to allocate those dollars.

ASSEMBLYWOMAN GALLAGHER: Okay. It was my understanding that also the stewardship funds were made available, and it's OASAS that's meant to allocate that.

OASAS COMMISSIONER CUNNINGHAM: In fact, the stewardship funds we actually also have -- the Department of Health also has part of those funds as well as OASAS, and they go to fund harm reduction and treatment affordability from both medication affordability and treatment affordability.

ASSEMBLYWOMAN GALLAGHER: Right. Because I know that the syringe exchange program and the Drug User Health Hubs were very effective in helping bring down death of users. And I am wondering -- I know that the funding stream has been having hiccups. There's been some issues with those

health hubs getting the funding.

And I'm wondering, what mechanism do you suggest we introduce to ensure that the Drug User Health hubs do not have their funding cut and are able to return to offering these lifesaving services that they were offering in 2020?

OASAS COMMISSIONER CUNNINGHAM: I mean, we certainly are providing dollars to the Department of Health, through the Opioid Settlement funds and the Opioid Stewardship funds, and then it's up to them to decide how they want to use those dollars.

ASSEMBLYWOMAN GALLAGHER: Is there any possibility that you could give those funds directly to the Drug User Health Hubs instead of going through the Department of Health, since they haven't been allocating the funding, so you're self-allocating it?

OASAS COMMISSIONER CUNNINGHAM: We really work through our agencies, because they're the ones who oversee the work at the health hubs, not OASAS.

ASSEMBLYWOMAN GALLAGHER: Okay.

Additionally, I'm wondering what it would take with the research that has shown across the board how effective overdose prevention centers are -- what will it take to get the Governor and OASAS to move these into -- and the Department of Health, to move these into actualization across the state?

OASAS COMMISSIONER CUNNINGHAM: So the issue really with overdose prevention centers are legal issues, that they're not permissible by state or federal law. And so we are investing in harm reduction that can withstand legal challenges.

ASSEMBLYWOMAN GALLAGHER: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblyman Santabarbara.

ASSEMBLYMAN SANTABARBARA: Thank you, Commissioners. Good afternoon, actually --

CHAIRWOMAN WEINSTEIN: I'm sorry, I'm getting confused because the Assemblymembers are sitting on the Senate side and the Senators are sitting on the Assembly side.

So we go to our cochair today,

Senator Brouk.

SENATOR BROUK: You're just testing me because I'm new. Yeah, I know.

(Laughter.)

SENATOR BROUK: Thank you. I'm just going to take my three minutes for a second round, because there was something I just wanted to dig into a little bit more, Commissioner Sullivan, when we were talking about the fact that in addition to CPEP obviously we want to see the Crisis Stabilization Centers and other ways to treat on that continuum of care.

So specifically when we're looking at youth, when it comes to the care that they need in crisis -- now you mentioned that in the Crisis Stabilization Centers that we are currently funding through the state there is, you know, a section -- or care providers for youth and for adults.

Has any thought been given to really dedicated, actual centers for youth? And I say that because locally we do have University of Rochester Medical Center, which

is creating a youth-focus stabilization center. And I wonder if there's something to be learned -- knowing the crisis that we're in for mental health specifically for young people -- from what they're doing, and potentially thinking of how we might be able to make these stabilization centers more focused on youth.

OMH COMMISSIONER SULLIVAN: The stabilization centers are really -- there's going to be a separate area for youth, totally staffed for youth. So it's -- I mean, they might be contiguous to the adult, but they are really stabilization centers that are focused on youth.

So in the new stabilization centers the youth have a special place, a special entrance, a special way to get services. They're also heavily staffed by family and peer advocates, so it involves an intensive kind of coordination of services for youth.

Our clinic system also usually has, throughout the CCBHC system, youth services. And those youth services are also somewhat

segregated from the adult services, even though they're in the clinic services.

We have a few youth -- we have two, I think, youth CPEPs. And that's usually, though, in an area where there's a large volume, like there's one in New York City. So there can be separate -- it can be separate, but even within the stabilization centers, the youth services are pretty separate and focused on working with youth specifically.

SENATOR BROUK: Okay. So presumably then a young person walking in wouldn't even be exposed to --

OMH COMMISSIONER SULLIVAN: Right, exactly.

SENATOR BROUK: That's helpful.

And then the other thing I wanted to quickly say is are you familiar with the proposal from the -- we talked about the Healthy Minds, Healthy Kids study that came out, we looked at the need for more service providers for young people. The wait times, we know, the waitlists are way too long.

Have you considered or have you looked at the proposal to infuse another $195 million specifically into children's services, especially as we look at outpatient services?

OMH COMMISSIONER SULLIVAN: We've really been investing a lot of dollars into children's services. I didn't talk too much about the Critical Time Intervention Teams, but those are going to be working with youth and hospital EDs in crisis and connectage to brief residential. In a few years we will have over 6,000 slots for home-based crisis intervention.

So there's a lot of investment that is going into the intensive crisis work with youth.

SENATOR BROUK: Thank you.

CHAIRWOMAN WEINSTEIN: Now Assemblyman Santabarbara.

ASSEMBLYMAN SANTABARBARA: Thank you.

And thank you, Commissioners, for being here.

Commissioner Neifeld, great to see you

here again. Thank you for being in my district and meeting -- actually you met my son at one point, and I appreciate that.

I just wanted to circle back to the residential placements that's been brought up here a few times. According to my notes, the past few years there's been a reduction in certified residential opportunities -- an 8 percent reduction, actually -- and day opportunities, a 16 percent reduction is what I have. And at the same time the population has grown, and the number of children being served has grown as well, leaving many families unable to access needed services or students sometimes even being placed out of state.

In addition to this, it's led to more students overstaying their residential school after they've aged out. And I'm going through this right now. So I've heard from constituents on this issue, but also I'm going through it firsthand. My son is aging out, and we've been in the process of trying to find a placement for the past couple of

years, and there's very few opportunities. And the ones that they have offered have been in New York City or a long distance away, which would essentially take away his family life, which is problematic in a number of ways.

So my question is -- and I think part of that is due to the staffing crisis and the inaccurate rates. My question is, will OPWDD commit additional resources for residential schools to keep students in the state and near their families, and to keep individuals near their families once they are out of that system and looking for a placement as well, and funding to address the workforce crisis that's the real cause of all this?

OPWDD COMMISSIONER NEIFELD: Okay, that's a lot to unpack.

We are -- so for the residential schools, just in terms of the funding, we partner with the State Education Department, so the educational component of a residential school placement is paid for the schools -- the student's home district. And for -- I'm

sorry, the educational piece.

The residential piece is paid for by OPWDD. When a student ages out, OPWDD does incur the cost of that -- of their living expenses until they are able to move into a certified setting within the OPWDD system.

We're doing a number of things to try to move the needle for students who have graduated and are remaining on a residential school campus. I mentioned earlier in testimony about the comprehensive adult transitional homes that we're opening within our state-operated programs, recognizing that the transition from a residential school into community-based living can be very difficult for students to manage. And they're two very different settings, and oftentimes we see that that can be a block for students being able to find an adult opportunity.

I think you hit the nail on the head as well when you were talking about your own experience, that all of our opportunities are voluntary. Right? There are no placements made or people assigned to vacancies. So we

go through a very intentional process of understanding the needs -- we can have more conversation offline about the other things that we're doing. Sorry.

ASSEMBLYMAN SANTABARBARA: Thank you for your answer.

CHAIRWOMAN WEINSTEIN: Thank you.

So there are no other Senators with questions, so we'll just be going through the list of Assemblymembers who have questions.

So next, Mr. Blumencranz.

ASSEMBLYMAN BLUMENCRANZ: Thank you so much.

I'm grateful that the Governor included the loan forgiveness for mental health professionals in our schools. Our students are in crisis, and I know a lot of the providers in my district are hungry for ways to hire more clinicians in the schools.

But I also know that we're facing a public safety crisis as well, and I find that one of the ways we could try and tackle that is through providing a similar workforce development and loan forgiveness program for

mental health professionals. I know I had introduced it into this body. It was rejected in committee, but I continue to fight to see how we can strengthen our continuum of care both for those in incarceration and those who are on parole.

Is there a way that we're trying to improve the continuum of care for incarcerated individuals in order to make sure that we are decreasing recidivism and crime in our suburban communities?

OMH COMMISSIONER SULLIVAN: I think there's two ways. One, for the individuals who are in the jails and -- in the prison system, we have a whole system of care which really mimics the outpatient services in the community. So we have individual therapies, we have group therapies, we have crisis units within the prison. We have inpatient beds within the prison. So within the prison there is that total continuum of care.

Before someone leaves, if they have had issues in the community, if they have had very disruptive behaviors in the community,

there are special programs within the prison for 60 to 90 days before they leave -- sometimes longer -- to get special help for that transition from coming out of prison and into the community.

In addition, for individuals -- we have a pilot program for individuals on parole who maybe have minor violations in parole, preventing them from going back to prison, getting them the services they need.

And then we have the Front Door, which is all the diversion services which are in this year's budget, which include mental health courts, navigators in the mental health system, beds and forensic ACT teams to help individuals not get into prison or jail but be served in the community, with some supervision, and then have their charges dealt with in a different way.

ASSEMBLYMAN BLUMENCRANZ: Thank you.

Just another question. When it comes to addiction services, I know there's a lot of really strong research -- and we brought this up before here today -- surrounding both

psilocybin, ibogaine, and even some really promising studies on cessation of addiction and compulsive behaviors when it comes to GLP-1s that are proliferating in our communities.

Do you see that these could be part of the future of continued care for those with addiction issues in our communities?

OASAS COMMISSIONER CUNNINGHAM: I certainly see, you know, any option to address addiction, you know, is something that we should be exploring.

Our focus has really been on the FDA-approved medication treatment for opioid use disorder. We know it's effective, it reduces overdose deaths by 50 percent. So making sure that people have access to these medications that, you know, have decades of research behind them is really a priority.

ASSEMBLYMAN BLUMENCRANZ: Thank you very much.

CHAIRWOMAN WEINSTEIN: So we do have a Senator for questioning, Senator Ashby.

SENATOR ASHBY: Thank you.

Commissioner Sullivan, given peer-to-peer success and the Dwyer program's, you know, kind of longstanding success rate throughout the state and the Governor's proposed cuts into veterans' services, are you -- are you worried at all about this? Is this concerning to you, and the care that our veterans may receive because of these cuts?

OMH COMMISSIONER SULLIVAN: There are no cuts at this time to the Dwyer programs. The Dwyer programs are fully funded the way they were last year.

We are also doing further peer-to-peer work with something called CARES UP, which also works with uniformed personnel but also with veterans going through transition from a service to community. And that's a peer-to-peer service as well, which we are funding at additional sites across the state.

So those programs are funded -- there's actually been some increase in the CARES UP program in this year's budget. So we're not -- going to not have any cuts in the Dwyer program.

SENATOR ASHBY: That's good to hear. Because when I was looking at the veterans budget, there is a cut there, but funding for Dwyer comes through OMH rather than that.

And I'm very happy to hear of the expansion of peer-to-peer.

Are you looking to increase the amounts for Dwyer that the counties receive?

OMH COMMISSIONER SULLIVAN: That's not in this year's budget. But I think we're evaluating -- you know, many -- some of the programs we really just started in the counties about a year ago. So as we look at the needs, I think that's something we will look at into the future.

It's a very effective program. It really does a -- and it's not just mental health, it does all kinds of services for vets. So it's a very comprehensive program.

SENATOR ASHBY: I agree.

And there's also another program that's received some attention in the last couple of years, Dr. Bourke's RTM research that he's done through SUNY Albany and is

hoping to expand. And it's been -- it has gotten a lot of -- a lot of positive reinforcement through peer reviews as well, and it's something that I think we should consider including in the budget and addressing PTSD not only for our veterans but, you know, across the board.

Are you aware of that? Are you tracking his work at all?

OMH COMMISSIONER SULLIVAN: We have -- I'm aware of it. And I think that we can look into the program. There are a number of programs -- a number of approaches to PTSD, and that's one of them.

SENATOR ASHBY: I appreciate it. Thank you, Doctor.

CHAIRWOMAN WEINSTEIN: So we -- a number of Assemblymembers have left -- are coming and going because of committee meetings. So next we're going to go to Assemblywoman Darling.

ASSEMBLYWOMAN DARLING: Thank you, Commissioners, for being here and for your work for the State of New York.

I'm going to ask two questions and try it this way, where I ask both questions at the same time.

So the first question, following recent visits from individuals and organizations reporting understaffing concerns, especially those working with children with disabilities, how does the office -- or OPWDD -- ensure adequate staffing levels despite increased funding for psychiatric rehabilitation and developmental disability programs?

OPWDD COMMISSIONER NEIFELD: So how do we ensure adequate staffing, is that the question?

ASSEMBLYMEMBER DARLING: Yes. especially as we're having like the workforce development issue right now.

OPWDD COMMISSIONER NEIFELD: Right. I mean, I think we have -- we do not have mandatory minimum levels of staffing because all of our services are person-centered and really based on the individual's need.

We do a lot of work with our care

coordination organizations, providers of services, our own regional office, and then obviously when it relates to our state-operated programs, to understand an individual's need, understand the level of staffing that needs to be there in order for, you know, them to have, you know, safety measures met and also for them to be meeting their goals.

So that is, you know, individually determined by the person, and then we work with providers to ensure that those levels are met.

ASSEMBLYMEMBER DARLING: Okay. And my next question is, how does Governor Hochul's allocation of 13.7 million in additional federal reimbursement for the implementation of prevention services mandated by the Family First Prevention Services Act address concerns about the lack of mental health services and overreliance on medication within the foster-care system, particularly given the distressing impact of family separation on children?

OMH COMMISSIONER SULLIVAN: I think that program is actually in -- I'm not that familiar with it. I think it's the Office of Children and Family Services. So I don't really know the details of that.

ASSEMBLYMEMBER DARLING: Okay, so I'll keep it to the mental health services. What in the proposed budget do we have that is going to address mental health concerns with foster children?

We've been receiving so many complaints and issues regarding different practices and how they are impacting children and families. The overreliance on medication is a major, major concern for parents and providers in foster care.

So just do we have any measures or any protocols that we're going to set in place with this proposed budget to address those concerns?

OMH COMMISSIONER SULLIVAN: Certainly all the crisis services and the intensive services that we have on the mental health side can work also with foster-care kids.

But the foster-care kids are under the Office of Children and Family Services, so the specific problems in terms of medication or other things, I am not familiar with, because it's not under the Office of Mental Health.

ASSEMBLYMEMBER DARLING: So is there any overlap between those --

OMH COMMISSIONER SULLIVAN: Yeah, some of the youth fall -- can be in some of our services, but they have a whole mental health system within foster care which is under Office of Foster Care Services, which is separate.

ASSEMBLYMEMBER DARLING: Thank you for that clarity.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblyman Burdick.

ASSEMBLYMAN BURDICK: Yes, thank you.

And thank you all for your testimony.

First for Commissioner Neifeld first, I want to thank you for your kind words and your testimony and your agency's terrific effort to expand employment opportunities for people with disabilities.

I'd like to support the request we've heard today for the 3.2 percent COLA for DSPs and 4,000 wage enhancement.

Commissioner Sullivan, I wish to commend and strongly support the Governor's proposed Article VII to prohibit out-of-pocket expense for insulin drugs.

And I'd appreciate your thoughts about extending this to EpiPen auto-injector devices for emergency treatment.

OMH COMMISSIONER SULLIVAN: That's really the Department of Health really looks at insulin.

ASSEMBLYMAN BURDICK: Oh, I'm sorry.

OMH COMMISSIONER SULLIVAN: That's okay.

ASSEMBLYMAN BURDICK: So back to Commissioner Neifeld. You mentioned in your testimony that one of the major things that you're working on is infrastructure. And in previous conversations, you know, we're concerned about how long it's been taking in order for changes in self-direction budgets. And I'm concerned that how long it might take

for all the IT and such would further delay trying to speed up the process in reviewing changes.

And I'm wondering if you could address that.

OPWDD COMMISSIONER NEIFELD: Sure.

I think overall our process for approving -- reviewing and approving self-direction budgets has greatly improved since last year. You know, our backlog has essentially gone away and, you know, because Governor Hochul has -- one of the first things that she did was lift the hiring freeze for agencies. We were able to recruit and train enough staff to be able to do that.

As you referenced, though, it is a largely manual -- fully manual process, and we're serving close to 30,000 New Yorkers now through our self-direction program. So the infrastructure piece, the IT intervention is critical. And we're working on that, and we don't expect there to be a delay.

ASSEMBLYMAN BURDICK: Could I ask you if anything might be able to be done in the

interim. You know, for example, the thresholds for approvals or who might do the approving, such as whether the financial intermediary might have some limited authority below a certain dollar limit.

Is that something you'd entertain?

OPWDD COMMISSIONER NEIFELD: There is limited authority below a certain threshold. But we also, you know, need to work to make sure that decisions are being made and coordinate our -- you know, in compliance with the rules and the regulations. And I think part of that will be the IT system will help with that a lot.

But we do -- there are certain thresholds that FIs have authority to approve up to.

ASSEMBLYMAN BURDICK: Great.

Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

To the Senate.

SENATOR BROUK: Thank you.

Next we'll have Senator Mannion for his second round.

SENATOR MANNION: Thank you. Thank you.

Commissioner Neifeld, we've talked a little bit about the ITOs and the progress that's happening there. There's -- all too often I think we're hearing about individuals that are in inappropriate settings. They're in -- you know, they're in hospitals, they can't be discharged.

I wanted to mention and get your thoughts on if there's any appetite for support of this bill, maybe even, you know, you could advocate in the budget process for a training program that's actually being developed right now at the University of Rochester for healthcare workers to work specifically with individuals with disabilities. There's instances out there where unfortunately there may be some improvements that could occur as far as the care and the engagement with those individuals.

So the piece of legislation that I have is to reduce premium costs for

malpractice insurance for individuals that are physicians or otherwise. So do you see a place for that, certainly in the space? And do you and your office see examples or have you seen an increase in examples of negative situations that have occurred in a healthcare location?

OPWDD COMMISSIONER NEIFELD: So I'm not familiar with the legislation. I'll have to look at that with the team and certainly we can work with the Executive to be responsive.

I think we know that when someone is going to an emergency department or a similar setting, that those doctors are not specially trained to work with people with developmental disabilities. And of course, you know, not just those doctors, but the staff of the hospital. And of course I think we see the impact of that.

We have recently begun working with the Department of Health really looking at this issue. We hosted -- Dr. McDonald hosted a grand round, he does four commissioners

grand rounds. He invited OPWDD providers from within our system to share with doctors and nurses about the need for specialty training to work with people with developmental disabilities.

We have within our own agency a technical support team, and something that they have done is actually go to hospitals, work with the personnel at hospitals to understand the individual needs of the person that they're serving related to their developmental disability. And it has helped speed up the process of having them find other opportunities.

So I do think it's a need. It is an area that we're working on. Would be happy to take a look at the bill and see how that might be helpful.

SENATOR MANNION: Thank you.

CHAIRWOMAN WEINSTEIN: So we go next to Assemblymember McMahon.

ASSEMBLYWOMAN McMAHON: Thank you, Chair Weinstein.

And thank you, Commissioners, for

being here today.

My questions are for Commissioner Neifeld. I think we've pretty much covered the COLA and the wage enhancement obviously. I see its importance and support it. But I'd like to talk a little bit about housing.

Unfortunately I don't think we have sufficient housing opportunities for all the people that need them. In Western New York alone, it's my understanding that there are hundreds of people on a housing priority list and they're waiting for housing opportunities that don't exist for them.

And as parents and caregivers age, the problem only becomes more serious. At one hearing, I think maybe last year, we talked about OPWDD doing an inventory of housing opportunities versus people. And I'm wondering if that has been done and what the results of that are.

And then, second, I noticed in your testimony you talked about the $15 million investment in community-based supportive

housing. I'm assuming this is maybe the FOFILLS? Or no --

OPWDD COMMISSIONER NEIFELD: It's different.

ASSEMBLYWOMAN McMAHON: -- maybe? Yeah, maybe.

So we have these initiatives to provide housing, non-certified housing, but I think the need for certified housing is still huge and still there. So how do we solve that problem? Is it just a question of capital? Staffing? What is it?

OPWDD COMMISSIONER NEIFELD: Yeah, I think -- you know, I don't have the numbers off the top of my head, but certainly we can follow up with the committees to share the number of vacancies versus the number of people who are expressing an interest in housing opportunities.

I think what we know is that there are sufficient vacancies within the system, and that we're really talking about the need for staff to staff those vacancies. Right? A vacancy within a home is not really valuable

unless there are the staff there to support the individuals who need those services.

So that's certainly the area that I think we're continuing to focus on, is bolstering the workforce to be able to staff those opportunities.

Some other things that I just think are worth mentioning, the $15 million capital investment that you referenced is in our Integrated Supportive Housing Program. So that's a capital investment to develop supportive housing for people with developmental disabilities so that they can live independently.

I also referenced our housing subsidies. So we can pay a housing subsidy for people to live independently. And I think the interrelationship there with certified housing is that for everybody who can and wants to live independently and has the opportunity to do so, that's an opportunity within a certified setting that doesn't have to go to someone who doesn't need that level of care and can be available

for someone who does need that level of support.

So that's why there -- it's critically important that we continue to develop that continuum so that people have access to the least restrictive housing opportunity, you know, that they need. And that's an area that we're very focused on. The Article VII -- the legislation related to the Nurse Practice Act that would allow DSPs to perform basic nursing skills in the community, that's also critically important to that.

ASSEMBLYWOMAN McMAHON: Thank you very much.

CHAIRWOMAN WEINSTEIN: We go to Assemblyman Palmesano, three minutes.

ASSEMBLYMAN PALMESANO: Yes. My question first is for Commissioner Sullivan. Don't want an answer here, as we'll need to put it in writing because of the time.

I want to talk about the issue of suicide. I have a family in my district that lost their 30-year-old son to suicide. And

since then, they've been advocating for changes to the mental health system, or lack thereof, that failed their son and their family. As many others who have lost their children to suicide believe, they are reaching out for help but can never get the help they need.

So my question that I want to answer back in writing is what can I tell that family that this administration is doing to try to address this issue? What should be done to help make sure tragedies like this don't happen again?

And also, I know there's a lot of money being talked about for mental health, which is great. What about transparency and assurances you can provide us that some of that money is making it to our rural areas that desperately need this assistance too? So if that's something you can follow up in writing, I'd really appreciate it.

OMH COMMISSIONER SULLIVAN: Mm-hmm.

ASSEMBLYMAN PALMESANO: Commissioner Neifeld, I want to speak to you. I kind of

want to go on record as well for the support for our direct support professionals. As someone who actually worked as a DSP over 20 years ago, I saw firsthand the impact on the quality of life and quality of care our DSPs can make for our most vulnerable population, those with intellectual and developmental disabilities.

So when I see 1.5 percent in the budget, that's woefully inadequate. Even the 3.2 percent that's being talked about is woefully inadequate. And as you know, budgeting is about priorities. And when we see -- if we're not providing care for our most vulnerable citizens, like those with intellectual and developmental disabilities, what does that say to us about our state's priorities?

And then when I see programs like $700 million for the Hollywood film tax credit or 2.4 billion for the migrant crisis, but yet here they have to come up here every year and basically beg for a COLA -- and we know the wage discrepancy that's between our

state-supported workers who are working versus those in our not-for-profits -- also, there's a wage discrepancy between our direct support professionals and the fast food industry.

I've known DSPs that went to work -- they want to stay in that profession because they care and they want to help, but they can only do it for so long before their back breaks to take care of the family and they go work for McDonald's or Taco Bell, and losing people there. That's a problem.

So we need to be more serious about addressing this issue moving forward. I did want to just ask you, on the waitlists -- I know it was mentioned -- do you have waitlists that you can provide us, how many people in different areas that we can see, that you can share with us?

And also I also heard from homes, from people that were at homes that have been shut down because there was not the staffing. Do you keep track of those homes so we know how -- because I know we had issues during

COVID. Is that something you could share and provide to us as a committee as well, if you know what I mean?

OPWDD COMMISSIONER NEIFELD: Sure, I understand. Appreciate your support of the workforce and your work as a DSP; I just want to acknowledge that.

We don't have a waitlist for housing services. We do have a process by which we prioritize individuals who have expressed interest. I will follow up in writing to the committees.

ASSEMBLYMAN PALMESANO: Okay. Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

We go next to Assemblyman Norris.

ASSEMBLYMAN NORRIS: Thank you very much, Chair Weinstein.

My question is for Commissioner Neifeld -- two questions. It has been reported, from my understanding, that OPWDD has closed some 150 group homes, IRAs. It is not authorizing private nonprofits to establish any more group homes.

What is your plan to provide housing for the approximately 5500 people with disabilities who are serviced through traditional Medicaid service on OPWDD's waiting list for certified group home spots?

OPWDD COMMISSIONER NEIFELD: So we have temporarily suspended homes within the state-operated system. Those homes are not closed, they're not permanently taken offline. We have certainly worked to reopen many homes as staffing allows.

Typically the reason that those homes are temporarily suspended is related to staffing. So the work that we're doing is not to open, you know, additional or, you know, commit capital dollars to opening or building new homes, but to supporting our workforce and bolstering the workforce. We've done a lot on the state-operated side to increase recruitment and retention.

On the -- I'm sorry, I'd lost track of all of your questions, I apologize.

ASSEMBLYMAN NORRIS: That's -- it was my main question, but I'll follow up with a

second question, if that's okay.

OPWDD COMMISSIONER NEIFELD: Please.

ASSEMBLYMAN NORRIS: In addition, there are 30,000 more who are serviced through the self-direction program. That's my understanding. Some 10,000 are seeking or shortly will be seeking non-certified housing of their own choosing. It is reported that OPWDD is not fully cooperating with families who want to establish their own independent living arrangements, and in some cases threaten to stop existing services if the person with a disability moves out.

So will you change this policy? And what will you do to achieve OPWDD's purported goal to enable these people with disabilities to live independently with proper supports? It is, in my opinion, very important that we allow these individuals to live independently, and to do everything that we can from the administration's point of view -- and our point of view -- to achieve that.

So I'm just trying to narrow it down

and hear your feedback on that very important issue.

OPWDD COMMISSIONER NEIFELD: Sure. We agree, which is why we've invested in our housing subsidies and in supportive housing and continue to do that and are open to having conversations with providers and with families who think they have creative ideas.

We are also very much committed to integration and to, you know, upholding the federal standards related to Olmstead and HCBS settings where we're not creating uncertified institutions. So that's why this conversation is nuanced. It's really -- it's one that we need to have project-based, to understand how these are integrated opportunities for people in the community and not just, you know, building an apartment building for people with developmental disabilities only.

ASSEMBLYMAN NORRIS: Thank you.

CHAIRWOMAN WEINSTEIN: We go to Assemblyman Braunstein.

ASSEMBLYMAN BRAUNSTEIN: Thank you.

And I want to thank all the commissioners for your testimony today.

My question is for Commissioner Sullivan. In your testimony I appreciate that you referenced that OMH will work intensively with hospitals and emergency rooms to implement new regulations for best practices in admission and discharge planning, including the requirement to ensure individuals are not discharged without an appropriate plan or access to follow-up services.

I also appreciate the investment in mental health navigators to working with county courts, with the courts' mental health coordination teams and local providers, and refer individuals to treatment and services.

Unfortunately there are some individuals who, despite best efforts of encouraging treatment, will refuse. And sometimes severely ill individuals cycle through -- they wind up in the hospital time and time again and they wind up in the court system time and time again.

My question is, at what point does the state intervene with mandatory treatment? And with the hospital system, who initiates that process? In the courts, who initiates that process? How often does it happen? What are the standards? I'm just curious about how we approach that situation of a person who time and time again, despite the state's best efforts to get them treatment, refuses and winds up in the hospital and the criminal justice system.

OMH COMMISSIONER SULLIVAN: There are actually a number of ways.

On the hospital system, individuals can either come or be brought to emergency rooms. And within emergency rooms for admission there is the ability to involuntarily admit someone, even if they don't think that they need the treatment, for whatever period of time that they may need it to get well. There's also the ability for individuals to have longer stays in state hospital systems.

So on the hospital side, it's usually

because someone is felt to be seriously impaired functionally, so they're perhaps dangerous to self or others, or have a serious issue with neglect. And those individuals can get admitted.

On the other hand, families can also petition for someone to be evaluated. Departments of social services, DCSs in communities, they can also have someone brought for an evaluation. So there are a number of ways that you can enter that part of the system.

There's also something called assisted outpatient treatment which New York State has, which is something that really provides a lot of services but also a judge and a court that says that you have to partake in those services. And that assisted outpatient treatment has many legal safeguards, but it is usually for individuals who have had the kind of repetitive issues that you're discussing.

However, all that said, the most important thing is the intensity of

outpatient services when someone's in the community. And that we are growing, so we can avoid hospitals and AOT and get people better.

ASSEMBLYMAN BRAUNSTEIN: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblywoman Kelles.

ASSEMBLYWOMAN KELLES: Thank you all for being here.

I'm just going to run through really quickly because the list that we all have is way longer than the time we have.

But just for Commissioner Sullivan to start with -- can you hear me now? Okay. So last year's budget we had 890 million for beds; that was supposed to be for 1300. My understanding is at the end of this year we'll have 330 total. We have 130 already.

Do we -- I guess, what is the timeline to get all those 1300? That's not including the additional couple of hundred for this year that we've added to the budget again. And do we have staff for these?

OMH COMMISSIONER SULLIVAN: There's

inpatient beds and then there's residential beds --

ASSEMBLYWOMAN KELLES: So last year there was 890 million put in that was capital for the 1 billion for mental health --

(Overtalk.)

OMH COMMISSIONER SULLIVAN: Yes, and that was largely for residential beds in the community.

ASSEMBLYWOMAN KELLES: Correct.

OMH COMMISSIONER SULLIVAN: And those are -- all the requests for proposal for those beds will be out by the end of March. And some of them will start to appear -- if they were apartments, a number of those have already been awarded and they will be filled very quickly.

If it's capital that goes towards building beds, then --

ASSEMBLYWOMAN KELLES: So we've already allocated all the -- I'm sorry, I have --

OMH COMMISSIONER SULLIVAN: All the RFPs will be out. They will be out.

ASSEMBLYWOMAN KELLES: Great. Great.

And I'm just going to point out something, read some data, because it would be good for all of us to have on the record, because I know we're all -- we're all struggling with the same thing, we want to solve these problems. So it's just good to have this.

These are the COLA adjustments that we've had over the last 10 years. 2013, inflation was 2, increase was zero. 2014, inflation was 2, increase was zero. 2105, 0.2, we got the {inaudible} to an increase. 2016, 0.8, we got zero increase. 2017, inflation was 1.7, we got a zero increase. 2018, inflation was 2.9, we got a zero increase. 2019, inflation was 1.8, we got a zero increase. 2020, inflation was 1, we got a 1 percent increase. 2021, first one, 5.4 was inflation, 5.4 was the increase. 2022, 8.5 inflation, 4.0 increase. 2023, 3.2 -- we asked for the 3.2 that year. Again, we're at I think 3.2 inflation, right, we have a 1.5 proposed.

COLA is a cost-of-living adjustment. It's not a wage increase. So I read this all to show that the data is basically going like this (gesturing up) where we -- all providers are getting a wage reduction, in effect. Right? Because cost-of-living adjustment is to maintain just at inflation.

So we are seeing across the board a decrease in providers. I'm seeing a huge vacancy rate in every single area, from OASAS to OPWDD to Mental Health in my communities.

Do you think that, I guess in a nutshell, that 1.5 is enough to backfill and change the direction of this? Would you consider it an actual wage increase?

CHAIRWOMAN WEINSTEIN: So --

ASSEMBLYWOMAN KELLES: You can answer offline.

CHAIRWOMAN WEINSTEIN: We'll all wait to hear your answers sent to the committees, and we'll make sure to share with all of our colleagues.

So next we go to the chair of Disabilities, Assemblywoman Seawright.

Second round, three minutes.

ASSEMBLYWOMAN SEAWRIGHT: Thank you.

I'll ask my three questions and then if you'll answer or get back to me if we're out of time.

Self-direction. Although there are no new directives that have come from OPWDD, fiscal intermediaries are clawing back on approving community classes. How can that system be improved?

And then, second question, I'm deeply concerned by the recent OPWDD rules change that undermines the Family Support Services program. How many families have been impacted because they are deemed paid caregivers? And then I believe Senator Mannion and I have both sent letters opposing that administrative rule change.

The third question, you mentioned rebasing that will occur July 1st. Based on your analysis, how will the agencies be penalized for paying more to DSPs? And what can agencies expect as an impact to their rates?

OPWDD COMMISSIONER NEIFELD: So on the FSS ADM -- I'll start there -- we worked very closely with the Family Support Services Council. We have a statewide council that advises and that we interact with routinely to issue the updates to that ADM. The updates were in the area of family reimbursement and were made to provide, for the first time since the program's inception, guidelines around what can and cannot be reimbursed and what the parameters are around that.

We have obviously since that time heard feedback from people who use the family reimbursement program, and we have been working with both the local councils and the statewide councils to understand those concerns and to address them. The councils have done their own work to pull that information together, presenting it to us, and we're in discussion about potential updates to the ADM that will reflect, you know, some of their concerns.

With regard to community classes, I

mentioned earlier that there have been no changes to the way the community classes are administered. We have over 90 FIs across the state. And so ensuring consistency of practice and ensuring that all those FIs understand the rules in the same way is a monumental effort on behalf of the agency, and we are certainly working toward that.

So some of the things that we're doing will be requiring FIs to have an appeals process so that if an individual who's self-directing or their family member feels that a denial was made in error, they can bring that to the FI.

We'll also be requiring that they work together on communities of practice to understand and discuss what the classes are.

But the classes do exist, and the opportunity for people to use their self-direction budget to take community classes exists within parameters. There's parameters around what is and is not allowable that comes from both the state and from the federal government, and they cannot

replace existing Medicaid services. And they must be integrated and open to the community.

And again, you know, those are part of our agreement with CMS on how we administer this program. So those parameters must be upheld, but we are working to make sure there's consistent understanding.

And we can talk more about the rebasing in a response letter.

ASSEMBLYWOMAN SEAWRIGHT: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to actually our last questioner -- no, not our last questioner. Next we go to, for a second round, Assemblywoman Gunther.

ASSEMBLYWOMAN GUNTHER: (Mic off.) I just have one question. I had taken a behavioral health {inaudible} prison in New York State, and I went from place to place to see like what was happening with mental hygiene in prison, et cetera. One thing that I was kind of shocked about was the use of Suboxone, and what -- like how that -- how is that able -- like somebody

said that you just have to say that "I have a past history of addiction." And I spoke with some of the employees there and they talked about the fact that, you know, they put their piece of paper in here (gesturing to cheek) and so forth and so on, and the usage of it, and they felt it was a little excessive.

And there are people that are -- you know, there are ways that you can put it in your cheek and not let it be absorbed into your body, so they were talking about that.

And I just thought, you know, that's kind of a strange thing that people are using those kinds of medications in prison and, you know, we don't want to see anybody addicted with those kinds of needs. And there's -- there weren't any rules and regulations. They don't take a history of people and, you know, go through addiction, what happened, those kinds of things. It's just on somebody's word. And they are selling it back and forth. I don't know if you've heard that.

OASAS COMMISSIONER CUNNINGHAM: I

mean, in order to get treatment, people are assessed and really need an opioid use disorder diagnosis before getting treatment with something like buprenorphine. So an assessment does need to happen, and a diagnosis.

But certainly diversion is a real concern in the carceral setting, and there are different formulations of buprenorphine. We have a TEACH in fact right now, working with the medical providers in carceral settings, to provide education and training. But there are different formulations, so there's an injection for buprenorphine so that if what you described, you know, happens, that there then are opportunities to have a different way to administer medication which is less likely to be diverted.

ASSEMBLYWOMAN GUNTHER: Mm-hmm. I didn't know if it was true or not true, but some of the people that worked there just had mentioned it.

OASAS COMMISSIONER CUNNINGHAM: Yeah, we have also heard it as well. And I think,

you know, again working -- we are working with the medical providers in carceral settings to have a discussion about the different treatment options and including the different ways which medications can be administered that can reduce risk of diversion.

ASSEMBLYWOMAN GUNTHER: Thank you.

CHAIRWOMAN WEINSTEIN: So now to close out the questions for this panel, Assemblyman De Los Santos.

ASSEMBLYMAN DE LOS SANTOS: Thank you, Commissioner, for your time here.

I'm trying to understand the comprehensive mental health system and the investment from Governor Kathy Hochul of 1 billion. How do you explain the fact that this is a historical investment, yet you have underserved communities like my community in Upper Manhattan and Washington Heights and Marble Hill that have not benefited from this investment, or this investment has not translated in reality to what we wish to see as it relates to mental health?

OMH COMMISSIONER SULLIVAN: A lot of the programs and things which are starting will be coming out. And there's certainly places where basically, yes, those services will appear -- services for youth, services for adults, et cetera.

The RFPs that I had mentioned earlier are all now out and getting awarded, so we should be able to see in your area a significant increase in the services that you're looking for.

We're also doing a lot of prevention work, which is also going into communities, underserved communities across the state and across the city.

So the services may not have appeared yet, but they are online to come out and we're awaiting responses to RFPs and getting the services awarded.

ASSEMBLYMAN DE LOS SANTOS: I would also appreciate the opportunity to make this process for nonprofit organizations that already have been doing the work for many years in mental health services, for the

process to be less robatic {sic}, more transparent. We have a lot of nonprofit organizations and institutions that would love to capitalize on this opportunity, yet the allocation doesn't seem friendly to them.

How will you utilize the capital to make them feel that they can apply for it and that -- give them hope, right? Because we still have, after COVID, mental health, you and I can agree, has gotten worse.

OMH COMMISSIONER SULLIVAN: We have put out a series of RFPs, I think it's about $10 million, to work with underserved communities that work exactly with those individuals. Some of them are focused on suicide prevention; a lot of them are focused on youth. And they work with agencies and groups that are not the traditional mental health system. So for example, Community Life, which works with adolescents, there's something called Step A which works in the Cypress Hills areas.

So -- and there's another series of those RFPs which will be coming out as well.

They're specifically geared to work with communities that -- and with often grassroots organizations to work with us to provide services that are not the traditional services.

ASSEMBLYMAN DE LOS SANTOS: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Maher.

ASSEMBLYMAN MAHER: Thank you.

Thank you all for your testimony and for answering so many of our questions.

For Commissioner Neifeld, I just want to echo my colleagues on both sides of the aisle. We do believe that 1.5 percent COLA is not enough. We are absolutely going to advocate and hopefully in that final budget it's a minimum of 3.2. That is our goal.

But staying on that topic, it's my understanding that for integrated supportive housing there's 15 million that OPWDD funds. And with inflation going up, it seems similar to that 1.5 percent. If we're looking to support that housing, why isn't that number going up with inflation? It seems it

probably needs to be doubled.

OPWDD COMMISSIONER NEIFELD: This was a question that was raised to me just yesterday. I think it's a great question.

I think what, you know, I committed to doing when I was speaking to some of the providers was going back and looking at the pipeline of projects, understanding how over the last almost 10 years that we've been administering the program, you know, how many programs -- how many projects are we awarding, have the number of units gone down, right, what does the pipeline look like, are there projects that are being left unfunded each year. And then continuing to have those conversations with the Division of the Budget, the Executive and the Legislature on what we're able to do each year.

So we need to do a little bit more research and digging into the question, but happy to do it and follow up.

ASSEMBLYMAN MAHER: I'd love that. I'd love to see the data and then see where we are and on track and how we can

potentially increase that funding.

Commissioner Sullivan, I just want to say that I've read the Youth Mental Health Listening Tour Report, and it was fantastic. To see some of the recommendations from the youth was amazing. For me, what really caught my eye was they want a seat at the table. You know, they want to be part of the decision-making process.

And because OASAS and the Office of Mental Health are married in so many ways -- and I know we talked about encouraging that -- my question for you is, do we have a seat at the table for a high-school-aged youth in terms of the Opioid Settlement Board? I know I've gotten a list of names, but are any of those names an individual that is a high-school-aged youth?

OASAS COMMISSIONER CUNNINGHAM: None of those individuals are. However, most of those individuals are nominated by elected officials, and so there's a three-year nomination which will be coming up fairly soon. So, you know, certainly there is the

opportunity to nominate somebody who's young.

ASSEMBLYMAN MAHER: Would you support that, a high-school-aged youth on the board, helping to make decisions?

OASAS COMMISSIONER CUNNINGHAM: Absolutely. I mean, I think, you know, including people with lived experience is critical in the work that we do. And we actually just formed a new advisory panel called LEAP, for people with lived experience and living experience to have a voice at the table, to have my ear.

ASSEMBLYMAN MAHER: Oh, fantastic. Hopefully this conversation and discussion can turn that thought into a reality.

And again, thank you for your testimony and answering our questions today.

CHAIRWOMAN WEINSTEIN: Thank you.

And now we have -- and there have been a lot of committee members, and that's why members have been coming and going -- Assemblyman Anderson.

ASSEMBLYMAN ANDERSON: Thank you so much, Commissioners. And thank you,

Madam Chair, for this hearing today.

I want to just ask a question for Dr. Cunningham first. I'm introducing a piece of legislation that deals with making sure that there's access to overdose prevention drugs in residential spaces, called the HOPE Act. And I'm really hopefully that some of the resources that are being provided in the Executive Budget can be used towards that act. And just learning -- interested in learning more about what the agency's doing to help prevent overdoses that occur in residential buildings.

So that would be my first question. I'm going to try to get all my questions in and you all will answer.

Now, I think this one is for Commissioner Sullivan. Can you just talk a little bit about your efforts in making and involving and training local community members to help address the substance use disorder and mental health crisis across the state, some of the trainings that are happening to help those folks? Programs like

Engage, for example, how those programs are doing in helping expand training.

And then the last question I think is going to be for you, Commissioner Neifeld. When we're looking at the issues of pediatric drugs that are prescribed, a significant number of kids only get care in schools because they don't have primary care physicians. So I'm just wondering what resources are going to be available to make sure that students are having expanded eligibility and access to resources to be able to get treatment from primary care physicians in schools.

So that might be a little bit for all of you all, but I did my questions and then you all will answer.

OASAS COMMISSIONER CUNNINGHAM: I'll start.

So we're absolutely prioritizing efforts to expand access to medications and tools to reduce overdose deaths. So that includes -- we have a portal online where anybody, programs or individuals, can order

naloxone, fentanyl test strips or xylazine test strips. And we've already shipped out 70,000 naloxone kits, over 5 million fentanyl test strips and 4 million xylazine test strips.

So we are working with our programs, including residential programs, and the community at large. Anybody can order them, free of charge, and it will be shipped to them.

ASSEMBLYMAN ANDERSON: Thank you, Commissioner.

And then the second question for Commissioner Sullivan, please.

OMH COMMISSIONER SULLIVAN: Yeah, Project Engage is a very exciting project which works with individuals from the community being trained to be mental wellness workers in the community, members from the community.

The training involves mental health coaching, outreach, screening, et cetera. It's under an evidence-based program which is run by Dr. Milton Wainberg, and we are really

watching it very closely. It's going to inform I think our plans for a mental health paraprofessional system which will help expand the mental health workforce.

So Project Engage does some really great grassroots work, and it's at two sites in New York City.

ASSEMBLYMAN ANDERSON: I'm looking forward to learning more. And thank you, Commissioners, for all your answers.

CHAIRWOMAN WEINSTEIN: Thank you.

SENATOR BROUK: Okay, that will complete Panel A. Thank you so much, Commissioners, for joining us.

Next we will have Denise Miranda, from the New York State Justice Center for the Protection of People with Special Needs.

(Pause.)

CHAIRWOMAN WEINSTEIN: I just want to encourage the commissioners who testified, can you please -- and the members, if you have additional questions, can you please take your conversations outside so we can move on with the hearing.

SENATOR BROUK: All right, folks, we'll be starting the next panel, so if you could respectfully scoot out. Thank you. That's an official term. Thank you so much.

All right, so now we've got 10 minutes to hear from Denise Miranda from the New York State Justice Center for the Protection of People with Special Needs. Thanks.

EXECUTIVE DIRECTOR MIRANDA: Good afternoon, Chairs Mannion, Brouk, Seawright, Gunther, Weinstein, as well as your distinguished colleagues of the Senate and Assembly.

My name is Denise Miranda, and I am the executive director of the New York State Justice Center for the Protection of People with Special Needs. I'd like to thank you for the opportunity to testify regarding Governor Hochul's fiscal year 2025 Executive Budget proposal.

This year the Justice Center marked an important milestone, the agency's 10-year anniversary. For more than a decade now, New York has been home to the strongest

protections in the country for individuals with special needs.

In that time, it may have been easy to forget what brought us to the creation of the Justice Center. Before the agency's existence, scathing reports exposed a system that was ripe for abuse. Known offenders were rarely held accountable for their actions. Instead, they were shuffled from program to program, finding new potential victims with each move. The Legislature knew an overhaul was overdue.

The Justice Center has substantiated tens of thousands of cases in the last decade of service, holding subjects responsible for egregious conduct.

(Automated voice: "Sorry, could you say that again?")

EXECUTIVE DIRECTOR MIRANDA: Egregious conduct.

(Laughter.)

EXECUTIVE DIRECTOR MIRANDA: We've prevented violent criminals from entering the workforce and barred nearly 1,000 of the

worst offenders from working with vulnerable populations. We've also tracked trends and produced materials that can help prevent incidents from happening.

It might be easy to believe that abuse and neglect has been eradicated because of all of this work. Unfortunately, we continue to investigate shocking incidents. In the past year alone we've substantiated cases involving brutal physical assault, rape, and severe neglect. They're grim reminders of just how important the Justice Center work remains.

Further, we know that former staff members substantiated for the worst cases of abuse and neglect have attempted to regain employment nearly 300 times. Only the Justice Center stood between them and individuals with special needs.

I think it's important to point out that stopping bad actors from working in or reentering the workforce does not just help individuals receiving services, it also makes the system safer for the tens of thousands of

dedicated direct care professionals. The vast majority of staff members across the state are incredibly resilient and dedicated to New Yorkers with special needs. They deliver exceptional care under very difficult circumstances.

Recognizing the unprecedented stress on the workforce, the Justice Center is examining each case through a workforce crisis lens. This will allow us to determine if an incident occurred because of an isolated issue or a systemic concern that needs to be addressed.

Additionally, the Justice Center's proposed budget allocates funding that will allow the agency to take further steps to reduce case cycle time, which lessens the burden on the workforce. This year's Executive Budget includes $1.3 million in additional state operations funding. This money will provide 18 FTEs, allowing the agency to continue our efforts to reduce cycle times.

We are mindful of the critical role we

can play in ensuring accountability and high-quality care, which requires quick resolution to cases.

As we look ahead to the next decade of service, we know the core mission of our work will carry on. But beyond that, we want to leverage our wealth of data to stop incidents from happening. Intense trend analysis and an evaluation of what providers and staff need to train and support the next generation of the workforce will be a focus of our agency.

In addition, we understand the key role stakeholders play in the success of the agency, which is why we will be working to strengthen these partnerships and build new ones. We started this initiative last year with a series of roundtables, where we peeled back the good and the bad, so we can move forward together.

We regularly interact with statewide advocacy organizations, self-advocates, families, labor unions, and members of our advisory council to better inform our work

and to find more innovative ways to support staff in the field.

We also present to providers all throughout the state about Justice Center processes and provide opportunities for candid conversations with the direct care workforce. We are eager to continue our collective work to enrich the lives of the people receiving services.

The Justice Center appreciates your partnership in our mission to protect all vulnerable New Yorkers, and I now welcome your questions.

SENATOR BROUK: Thank you so much.

First we will start with Senator Mannion.

SENATOR MANNION: Thank you, Director.

What we've seen particularly at OPWDD is a decline in rates for staffing. And, you know, a high number of vacant positions that are out there, high turnover. So with the declining rates of staffing across multiple facilities, has this affected the rates of reportable incidents or substantiated cases?

EXECUTIVE DIRECTOR MIRANDA: Sure, so thank you for that question. Obviously the workforce is dealing with unprecedented challenges right now, right, a host of which have been discussed earlier. I think one of the things that's been very consistent about the agency is the number of reports that come in and the percentages of those reports that are substantiated. Somewhere between 35 and 38 percent of the cases that are abuse and neglect investigations actually result in a substantiation.

The workforce -- you know, obviously we spent a lot of time earlier today talking about many of the challenges. But I think, you know, besides the obvious compensation conversation, we have to talk about mandatory overtime, we have to talk about education, we have to talk about lack of supervision. And these are all challenges that have been well-documented well before the creation of the Justice Center.

SENATOR MANNION: Thank you. Have we seen any changes as we've come out of the

pandemic related to the reportable cases or substantiated cases, you know, in the last, let's say, year and a half, two years or so?

EXECUTIVE DIRECTOR MIRANDA: Sure. So during the pandemic we did notice a decrease in reporting, and we attribute a lot of that decrease to the fact that family members and visitors were not able to often see and visit loved ones, and they are a source of reporting for the agency.

The numbers since then have resumed. We receive approximately 85,000 to 90,000 calls a year. Obviously the overwhelming majority of those cases are not abuse and neglect. But the cases are now returning to the original pre-pandemic level, which is about 12,000, 11,000 a year.

SENATOR MANNION: And as far as the Justice Center's own staffing, you mentioned the funding available and the number of FTEs. Is -- can you just make a comment on that as far as the necessity or the ability to do it or where we are right now or as we approach this budget season compared to historically?

EXECUTIVE DIRECTOR MIRANDA: Sure. So the $1.3 million that are new allocated funds will allow for 18 FTEs. Those resources will be dedicated primarily to our investigatory staff as well as our prevention efforts here at the agency.

We dedicate those resources to investigations primarily because we recognize the importance of timely and efficient investigations. While we do not make any decisions or play any role in the employee discipline process, we do realize that investigations need to conclude timely so that employers can make appropriate decisions based on the outcomes.

So our ability to put more resources on the ground to assist the many investigators at the agency who are tirelessly working every single day will be of great relief I think for the agency as well as for the providers and all stakeholders -- and individuals, obviously, receiving services.

SENATOR MANNION: Thank you, Director.

Thank you, Madam Chair.

CHAIRWOMAN WEINSTEIN: We go to Assemblymember Seawright.

ASSEMBLYWOMAN SEAWRIGHT: Thank you, Chair Weinstein.

And thank you, Director, for your testimony.

Would you say there was a correlation between the massive job hemorrhage that we're seeing and the number of cases that you see as a result?

EXECUTIVE DIRECTOR MIRANDA: So as I mentioned before, you know, the creation of the Justice Center right now dates back to 2013, and there was a report issued by Clarence Sundram which really enumerated many of the factors that were contributing to the workforce crisis that was in 2011-2012. Right? Many of those same pressures and difficulties exist today. The numbers remain relatively consistent with respect to the number of cases that are called in, the types of cases that we receive, and the rates of substantiation.

ASSEMBLYWOMAN SEAWRIGHT: I'm hearing from various people around the state. Here's one letter I received: "My cousin was abused in a group home 17 days ago. Why did the Justice Center refuse to investigate because he is nonverbal? This is discrimination against the most disabled. This is not unique. I hear from other families this is happening. He went to the hospital, had a broken clavicle. His family is afraid to let him go back to a group home."

EXECUTIVE DIRECTOR MIRANDA: So let me start by saying that it's the Justice Center's specialty and expertise. We do investigate cases for nonverbal individuals receiving services. We investigate hundreds of cases every single year for people who are, as you describe, nonverbal.

So I can assure you that no investigation, no case is turned away because of those factors. That's what's unique to the Justice Center, the expertise that we've been able to develop making sure that we're able to support individuals with special

needs, and interviewing techniques, technology, et cetera.

So I'd be more than happy, Assemblymember, to follow up offline with respect to this particular constituent and have further discussion to make sure that we can, number one, clarify what our process is and make sure that the case is guided accordingly.

ASSEMBLYWOMAN SEAWRIGHT: And thank you for that.

Can you provide a number for the number of DSPs that were suspended from their work because of unsubstantiated allegations through the Justice Center?

EXECUTIVE DIRECTOR MIRANDA: No, we don't have that data available, but I'm happy to follow up.

ASSEMBLYWOMAN SEAWRIGHT: How can we as a Legislature assist you to lessen the burden of large caseloads and keep New Yorkers with disabilities safer?

EXECUTIVE DIRECTOR MIRANDA: So I think, you know, the Justice Center is really

committed to making sure that there is transparency with respect to our operations. We do a Justice Center summit; last year we had over 1500 people attend. We do 90 presentations a year. I speak with labor organizations, provider associations, I speak directly with the workforce.

You know, we see the Legislature as a partner in making sure that we're explaining the purpose, the jurisdiction of the agency, and the processes. So to demystify, you know, some of the misconceptions that exist out there. So certainly we welcome the opportunity to speak with members in your particular district and share some more information about how we work and some of the processes that are in place.

ASSEMBLYWOMAN SEAWRIGHT: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Eachus.

ASSEMBLYMAN EACHUS: Thank you, Madam Chair.

For 37 years I've been involved with OMH, from the perspective of a parent and

of course now also as an Assemblyperson. And I'm glad you're here, because I've never heard of you. And I just from your discussion here, you do amazing work, and I appreciate what you and the Justice Center do.

The one thing that I would like to ask, though, is you talk about "we regularly interact with statewide advocacy organizations, self-advocates, families, labor unions and members of our advisory council." I fall into a couple of those categories; I'd be very pleased to get notifications from you and go to these meetings that you hold and be an active part of this.

EXECUTIVE DIRECTOR MIRANDA: Well, we will certainly make sure that you receive all the notifications. And I can tell you that in April we will be hosting our second online roundtable summit, Justice Center summit. It's a two-day event where we invite all the stakeholders in all the various groups that you mentioned, right, to come and to ask

questions, while we also go through all of our operations.

It's a two-day event, it's extremely informative, it's been very well attended, and so we will certainly make sure that we provide your office with that information. And it's in April.

ASSEMBLYMAN EACHUS: I appreciate that very much. Thank you.

EXECUTIVE DIRECTOR MIRANDA: Sure.

CHAIRWOMAN WEINSTEIN: Thank you.

SENATOR BROUK: Wonderful. Thank you so much. That will conclude questioning for this panel. Thank you.

EXECUTIVE DIRECTOR MIRANDA: Thank you.

SENATOR BROUK: The next panel will have -- sorry, we do have one question.

(Laughter.)

SENATOR BROUK: Just testing you, see how quickly you can get going. All right, Senator Webb, the floor is yours.

SENATOR WEBB: Thank you, Madam Chair.

I just have a question with regards to

the investigation process. So let's say, you know, there's an agency in our respective district that's under review. How is the community at large notified of the outcomes -- not just simply the families that maybe filed the complaint, but the community at large?

And the reason why I ask that is that I know the question was asked by one of my colleagues on how we can provide support, and one of the ways that we provide support as legislators is providing funding. And so knowing that there are organizations in our communities that are providing supports to residents who have significant special needs, and your agency is, you know, involved in the investigations, like how -- like take me through like your investigative process. Like how does that work? Like how would we know that, for instance, if we gave money to an agency that was found to be mistreating clients -- do you know what I mean? Like if you could take us through that.

EXECUTIVE DIRECTOR MIRANDA: So sure.

The process for an investigation starts typically with a call made to our call center. We operate a 24-hour, 7-day-a-week call center operation. There are mandated reporters within the community and within the various facilities under our jurisdiction; they're obligated to report any suspicion of abuse and neglect.

Those cases will come in, we will make the appropriate notifications at that point to the families and make sure that they're obviously aware of the processes. And notifications will also go out to the provider to make sure that safety planning occurs immediately.

The case will then get assigned to an investigator, assuming it is an abuse and neglect allegation, and the field staff will work that case up. That can include speaking to various witnesses, perhaps engagement with law enforcement, speaking with employers at the actual provider situation, and obviously interviewing witnesses, individuals receiving services.

Once the case -- the investigation is closed, that case moves over to our Office of General Counsel. And the Office of General Counsel will make a determination as to whether that case is substantiated or not. They will also make a determination with respect to the category level. Category 1 is our most serious and egregious category level. It is a permanent bar to employment in any of the settings under our jurisdiction. These are egregious cases of sexual abuse, physical abuse, sexual assaults, rapes.

Obviously very few cases fall into Category 1, but we've got Category 2, 3 and 4.

Once a case is substantiated or the determination is made by the Office of General Counsel, a notification goes out to the provider, and notifications will also go out to the family member.

Now, I know your question I think was focused on sort of sharing that information at large, but what I will say is that

statutorily there are some privacy provisions within the statute that limit how much information we're able to share. But notifications do go out to the provider as well as the family.

SENATOR WEBB: Thank you.

SENATOR BROUK: Okay, now thank you.

(Laughter.)

EXECUTIVE DIRECTOR MIRANDA: Thank you.

SENATOR BROUK: Now we will move to Panel B. I'm calling it even if they raise their hand.

So on Panel B we have the New York State Conference of Local Mental Hygiene Directors, Mental Health Association in New York State, and the National Alliance on Mental Illness for New York State.

So just as a reminder, each panelist will have three minutes for their testimony, and then every member, regardless of chair position, will have three minutes for questioning of the entire panel.

So let's -- I'll start you off, and

then you can duke out who does the second and third. But Courtney David, executive director for the Conference of Local Mental Hygiene Directors.

MS. DAVID: Thank you so much.

Good afternoon, Chair Weinstein, committee chairs and other distinguished committee members. Thank you for the opportunity to testify today regarding the Governor's Executive Budget proposal.

My name is Courtney David. I'm the executive director of the New York State conference of Local Mental Hygiene Directors. The conference represents the directors of community services for the 57 counties and the City of New York. The DCSs have statutory responsibility for the cross-system management of the local mental hygiene system for the services impacting adults and children with mental illness, substance use disorder, and intellectual and developmental disabilities.

As you continue to explore effective policy approaches to reduce the number of

individuals with serious mental illness from coming into contact with the criminal justice system, one major issue continues to hinder these efforts -- the state's competency restoration process.

Competency restoration is mandated by the court when an individual who's charged with a crime is found to be unable to understand the proceedings or is unable to aid in their own defense due to an active mental illness or intellectual disability. Section 730 of the state's Criminal Procedure Law governs this process.

Restoration services typically involve admission to a forensic unit and include administration of medication, education on the criminal justice system, and other services only to help stabilize an individual to be competent to stand trial. However, some judges believe they are helping defendants obtain appropriate treatment by issuing these orders.

It is estimated that between a quarter and two-thirds of all defendants mandated for

restoration cycle through the system multiple times on the same charge, equating to hundreds of people each year. Currently there is no requirement for OMH to consult with the county mental health departments on treatment planning, leaving decision making up to the state's forensic providers.

While the majority of 730 defendants can be restored within 90 to 150 days, there have been several cases where defendants have been held in restoration for three, six or even 10 years. This practice leads to further decompensation.

These lengthy confinements also violate the Americans with Disabilities Act, and other states have begun to reexamine and update their laws to avoid future legal action.

The daily rates for forensic placement range from 1300 to over 1500 dollars per day. In 2023, Oneida County paid $3.9 million, with a projected increase of 4.4 million this year -- and they are not alone.

Since 2020 the state has charged the

counties 100 percent of these costs, siphoning millions of dollars from the local mental hygiene system. The Governor's Executive Budget proposal seeks to expand this forensic capacity in fiscal year 2025.

To offer a solution, we and our colleagues at the New York State Association of Counties have proposed amendments to the statutory framework that governs this process. Chairs Brouk and Gunther have also acknowledged the importance of these reforms, and we thank them for their continued support and sponsorship of our bill.

Therefore, we strongly urge you to enact these reforms as part of this year's final budget so that 730 defendants are provided a pathway to receive appropriate mental health treatment and ensure millions of county dollars directed to the state's General Fund will be available for reinvestment back into the community.

Thank you.

MR. SHAPIRO: Good afternoon, Assemblywoman Weinstein, Senator Brouk,

Assemblywoman Gunther, and members of the committee. Thank you for the opportunity to provide testimony.

My name is Matthew Shapiro. I'm the senior director of government affairs for the New York State chapter of NAMI, the National Alliance on Mental Illness, the nation's largest grassroots organization dedicated to improving the lives of individuals and families impacted by mental illness.

NAMI-New York State envisions a world where all people affected by mental illness live healthy, fulfilling lives, supported by a community that cares. And I'm excited for the opportunity today to talk about how we can build that community that cares for the one in four families like mine who are affected by a diagnosable psychiatric disorder, as well as the countless New Yorkers who are facing mental health challenges.

Despite the positive momentum generated by last year's budget, too many New Yorkers continue to struggle to access

psychiatric services that are most appropriate for them. Community behavioral health providers continue to hemorrhage staff as our dedicated workforce struggles with caseloads that are unmanageable and, in too many examples, not paid a living wage for their herculean efforts.

Throughout New York our correctional system remains disproportionately populated by people living with a mental illness or substance use disorder who deserve treatment, not jails, and in communities, not cages.

New York's future, our youth, are in crisis and facing negative mental health stresses that would have been unimaginable just a decade ago. It's clear more has to be done. And there's a lot to celebrate in Governor Hochul's budget -- which once again adopts policy recommendations that we've been making for years -- and boldly aims to increase access for all those on the broad spectrum of psychiatric disorders.

Our written testimony has our six focus areas; I want to focus on two very

quickly.

Number one, the need for psychiatric beds. It's not a popular topic around here, but to be honest, those beds are very much needed. My family needed those beds. On three different occasions I've had to bring my mom into a psychiatric emergency room and have her admitted into the hospital. It's not a pleasant experience, I assure you; it's nothing that any family member wants to do. But it's at times something that we need to do to get her the necessary care.

But as unpleasant as that experience was, our family is among one of the lucky ones. As you said, Assemblywoman Gunther, one of the consequences that we're seeing from this are people being moved to another part of the state to access a bed. And this separates their family from the recovery process.

We were so lucky that we were able to support my mom all three times she was hospitalized. And families that don't have that opportunity have to make great

sacrifices to be a part of the process. We need to do better by them.

I only have 15 seconds, but we also very broadly support the criminal justice efforts that are in the budget, especially making 988 more equitable and including maternal mental health services. Again, Senator Brouk, you've been such a leader on this.

We also greatly support the expansion of mental health courts.

MR. LIEBMAN: Thank you. Thank you very much. Thank you, I really appreciate being here.

My name is Glenn Liebman. I'm the director of the Mental Health Association of New York State, MHANYS. This is my 20th year, and I've been testifying for 20 years. And, you know, I just want to say that you have been really instrumental in so many of the changes, so many of the positive changes that have happened over that time period.

So our organization is comprised of

26 affiliates in 52 counties throughout New York State. We largely provide community-based mental health services, but we also spend a lot of time on advocacy and training and education as well.

So what I want to say is that, you know, the Governor said that -- in the State of the State, that mental health is the defining challenge of our time. Couldn't agree more. Finally we have a Governor who's talking about this. And the funding she's put forward around this has been fantastic.

But, you know, like all of you, I'm going to echo -- you know, what we're hearing is that you have this great ship, you're steering this ship, you want to make the changes, and we support that 100 percent. But if you don't have the crew to run that ship, how are you going to succeed?

So this is why we are working so hard around the COLA. So we have about 14 issues that we're listing, but we're really focused very much on a COLA and a workforce investment.

So, you know, as the Governor added 1.5 in the budget -- and that's appreciated, it's something. We need a lot more. And we're urging your support for an additional 1.7 percent just to get to the 3.2 just for the CPI. That's what we want, and certainly we support a lot more.

And also -- and I appreciate, Assemblymember Kelles, you were going through the many years that we didn't get funding for, you know, any sort of support. And the reality is we've lost over $600 million in that time frame -- $600 million that would have gone to mental health has instead gone to roads and bridges and other things. I just imagine how much different our behavioral health system would look like if we had that kind of money. It would be remarkable. We wouldn't have to worry about -- I mean, we'd worry a lot less about homelessness, incarceration. People would be better served around this system.

So it's sad that we still have to deal with this. We're dealing with the tsunami,

the turnover, the vacancy rate. It's just really, really sad.

And there are a few other things -- we don't want to sit there and say, you know, COLA, COLA, COLA, because there are other things that we talk about as well.

Assemblymember Gunther has introduced a pension bill that studies how -- the impact to pensions for not-for-profits. We have 800,000 people in the nonprofit sector. We have had nothing in terms of a pension or a retirement system for the population. We need that. So we very strongly support the study bill.

We also have a series of recommendations around a pipeline bill, qualified mental health associations -- which Commissioner Sullivan briefly referenced. But those are the paraprofessionals that we need to get into our field. People talk about mental health all the time now. We have to get young people vested in our field.

So thank you very much.

SENATOR BROUK: Thank you all so much.

We're going to start the questioning on the Senate side for three minutes with Senator Palumbo.

SENATOR PALUMBO: Thank you, Chairwoman. How are you all? Nice to see you.

MULTIPLE PANELISTS: Good. Good to see you, Senator.

SENATOR PALUMBO: I just started thinking about these questions regarding the COLA, Mr. Liebman. So there were some -- and I believe there were some adjustments, there was -- in the fiscal year '23, that there was a 5.4 percent I believe enacted for that year in cost-of-living adjustments, and 4 percent this year.

And so this 1.5 percent is over that as well, adjusting for inflation -- or is it not? I just don't understand --

MR. LIEBMAN: No, that's okay.

So the 5.4 -- and by the way, you know, Governor Hochul deserves a lot of credit because she has been the only Governor in the last three who's actually

given a cost-of-living adjustment. So that's appreciated.

So the 5.4 percent was two years ago. Last year ended up being 4 percent; you added 1.5 percent from the 2.5 percent she added. Now, this year, she's put in 1.5 percent for this year. So we're trying to get to the point where we can get to the 3.2 percent so we can at least meet the need for -- you know, around the CPI. So that's -- yeah.

SENATOR PALUMBO: Sure, that's great.

And I know -- I mean, these have been just ongoing issues, of course, with other areas of employment getting minimum wage hikes and so forth. And with the tremendous work that folks do in this field -- you know, God's work, really -- we need to make sure that we fully fund it. So I do agree with you that that cost-of-living adjustment is nice so it doesn't become a Hunger Games where you're back here every year asking for a little bit more, and a little bit more, and a little bit more. To make this a statutory increase would be a wonderful thing.

MR. LIEBMAN: Thank you for that comment, Senator. Really appreciate it, because it's so true. And all of you have articulated so well why our direct care workforce, they love what they do. They're mission-driven. But they've got to put food on the table. You know, they really have to put food on the table. And you can be all the mission-driven you want -- I'm a -- my son is a direct care worker, so I know. You can put everything you want into that and all that mission, but the reality is you can go across the street to McDonald's and make more money than you do as a direct care worker in our fields. So that's got to change.

SENATOR PALUMBO: Sure. And it's such tough work that you -- that folks in your field are doing. We certainly respect that.

But thank you for your comments.

MR. LIEBMAN: Thank you, Senator.

CHAIRWOMAN WEINSTEIN: Assemblywoman Gunther.

ASSEMBLYWOMAN GUNTHER: (Mic off.) Well, my first thing is about the COLA. You

know, where -- am I on? I'm not.

UNIDENTIFIED PANELIST: You're always on.

(Laughter.)

ASSEMBLYWOMAN GUNTHER: I'm always on, yeah. If that's good or bad, I don't know.

UNIDENTIFIED PANELIST: It's good.

ASSEMBLYWOMAN GUNTHER: Anyway, the first thing that we're going to talk about is the COLA. You know, we were offered a smaller COLA. Now we're up to 3.2 percent. And I just want to understand what that would mean to somebody that's working in the mental health field. What's the average salary, and what does 3.2 percent -- I think that's an important question.

MR. LIEBMAN: So if I could answer that, right now we're at 1.5 percent. So we want to get to the 3.2 percent.

ASSEMBLYWOMAN GUNTHER: We want to get to 3.2. But even at 3.2 --

MR. LIEBMAN: So we need that 1.7 percent.

So, you know, I think it was

Assemblyman Bores who said would you -- what would that mean if you got a larger COLA. The reality is 3.2 percent is nice, and it will help, but you know this: It's not going to keep people in the field for long-term. We need a sustainable COLA.

We need -- you know, Senator Brouk has legislation out there about making the COLA standard. But we also need those long-term solutions like you have on the pension idea. And, you know, we have to figure out how we can keep people in our field. These COLAs are important, but -- you know, and again, 11 percent over the last three years, that's something, and that's going to be helpful. But we need something long-term and sustainable.

ASSEMBLYWOMAN GUNTHER: The next one is about, you know, we're increasing the number of mental health beds across New York State, which is important because we do need a length of stay. But -- and also, you know, this can get someone back on their feet.

But what happens after discharge is

what the problem is. And that's a big problem. So, you know, people keep cycling in, cycling in. So it's very important to talk about that and see what -- you know, we have to make some changes.

MR. SHAPIRO: Right. Again, what we want to see, Assemblywoman, is a coordinated, you know, care service. So, you know, someone who needs hospital services today hopefully will need community services tomorrow, they can get out and thrive in the community.

The essential thing is connecting them to the community providers. And, you know, again, this is an area where the Governor and OMH have made great strides in creating these teams, these coordination teams that connect people. But we still want to see the type of admission standards and discharge standards that NAMI expects to see. You know, we still have too many hospitals that are diverting people away rather than admit them. They discharge them before they're ready.

Again, I've experienced this three

times with my mom. In one example, I think they discharged her way too early -- she was back a month later. And, you know, these are the recycling things that we see and we're trying to prevent.

So again, we're going to be providing OMH with the recommendations that we have for admission and discharge standards and, you know, work better to coordinate care and get people connected to community services. It's vital.

ASSEMBLYWOMAN GUNTHER: Well, the short length of stay is -- they really impact -- sometimes they're giving medications and they don't see what the efficacy is of the medications. And so that's why we keep circling back round and round and round.

You know, what about -- you know, it's very difficult --

CHAIRWOMAN WEINSTEIN: Time is up.

ASSEMBLYWOMAN GUNTHER: My time is up?

(Laughter.)

ASSEMBLYWOMAN GUNTHER: I just wanted

to talk a little bit about pensions.

(Laughter.)

CHAIRWOMAN WEINSTEIN: To the Senate.

SENATOR BROUK: Great. Thank you all so much for being here and everything that you're doing every day to advocate for more mental health resources.

I know we've talked a lot today about COLA, but it's that time of year. So I'm going to talk about that again. I think hopefully we've made the case clear as to why I think a lot of folks are talking about needing more in this cost-of-living adjustment.

But one thing I'm curious about is, you know, we talk about recruitment and retention for how these adjustments have been able to help workforce-wise. How quickly do you -- have some of the organizations that you represent or work with, how quickly can they see the effects of that? In other words, have we already seen shifts in retention once folks knew that these COLAs were coming? Or was it -- was it too

difficult and, you know, people were still leaving because it wasn't necessarily an assured thing that it was going to happen every year? Have we seen any effects of it?

MR. LIEBMAN: So I just had one of our other agencies that are testifying today, the Association for Community Living, has done a great job in surveying the field and, you know, I'll let them speak to it. But I really think that it has had an impact in terms of retention.

It really -- you know, the numbers -- yes, the numbers are still way too high and our field still is starving for more funding. But it has sort of turned the tide a little bit. And the fact that we've had consistent COLAs for the last three years, hopefully this year again, the 3.2 -- will be something that will help turn the tide. But the reality, as you know, Senator, is we need a lot more. We need a real strong investment around mental health beyond just the workforce piece.

MR. SHAPIRO: You know, and one other

thing, too. We talk about diversifying the field too, and I want to thank you, Senator Brouk, for introducing a bill that would eliminate the social work exam, which separates a lot of foreign-language providers out of the system. And we knew that culturally competent care is needed and we need to diversify the system.

So, you know, obviously COLAs and financially supporting the system is important, but also looking at ways like you have to diversify the system and make it more inclusive.

SENATOR BROUK: Thank you.

And just to put a plug in for the bill, that would create a statutory COLA every year. But I think you could also maybe help us illuminate what that means to your field, you know, knowing that something is going to happen every year. I imagine even after three or four years of getting a COLA, individuals in this -- in these fields still don't think it's a guarantee every year.

MR. LIEBMAN: Absolutely, yup. No,

you're absolutely right. And we do have to have that passed, signed into law. It's a clear -- a major priority for us. So thank you for sponsoring the bill.

SENATOR BROUK: Beautifully said.

(Laughter.)

SENATOR BROUK: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Keith Brown.

ASSEMBLYMAN KEITH BROWN: Thank you, Chair. Thank you all for being here and for the work that you do.

I'm going to shift gears a little bit. My question is related to the legalization of marijuana. Have your members seen an uptick in mental health illness as a result of adults or children smoking marijuana?

MR. SHAPIRO: I don't know if anybody wants --

MS. DAVID: We don't have any statistics on that.

MR. SHAPIRO: Yeah. You know, we don't provide direct services, so yeah, we don't have any statistics about that.

ASSEMBLYMAN KEITH BROWN: Okay.

MR. LIEBMAN: You know, I can say from our end that we've really not seen that spike. But it wouldn't surprise me if those numbers did bear out that there would be some kind of spike.

ASSEMBLYMAN KEITH BROWN: And one of our colleagues before was asking the commissioners relative to potency. As you know, there's a provision in the budget to remove taxation of marijuana based on potency. However, several states are actually moving towards adopting potency levels similar to alcohol proof.

Would your organizations or your members support such a move in this state?

MR. LIEBMAN: That's a good question. I would have to get back to you. I'd have to talk to my board about it. But it's something certainly we would take serious consideration around.

ASSEMBLYMAN KEITH BROWN: Great.

Also, I think it was Commissioner Sullivan when she was in front of us was

mentioning, when talking about school mental health clinics -- that was a proposal in last year's budget -- there's a little known agency in the State of New York in the Office of Children and Family Services called the New York State Mentoring Program that was actually started by Mario Cuomo's wife.

Are you familiar with this? And has there been any effort to utilize their resources as it comes to helping kids deal with mental health issues in schools?

MR. LIEBMAN: You know, it's funny you talked about that because -- I forget what it's called now. I think it's got a different name --

ASSEMBLYMAN KEITH BROWN: New York State Mentoring Program.

MR. LIEBMAN: It is the New York State Mentoring Program? Because we have, over the years, been engaged with them to some degree.

So I really think it's incredibly important, any -- you know, we were talking about anything we can do to enhance our workforce opportunities. Mentoring is a huge

part of that. So certainly we will be more engaged with the mentoring folks in the future. And thank you for that.

ASSEMBLYMAN KEITH BROWN: Great. Feel free to reach out to them.

And last question, I raised the issue of the AG's report that came out December 7th. Have you all seen it and looked at the recommendations? Yeah?

By all means, a letter-writing campaign to the agencies and to us is I think important in order to change how the system operates and how we get people critical care.

Thank you so much for being here.

MULTIPLE PANELISTS: Thank you.

CHAIRWOMAN WEINSTEIN: So we're going to just move on to Assemblymembers.

Now, Assemblyman Anderson.

ASSEMBLYMAN ANDERSON: Thank you, Madam Chair.

And thank you all for all the work that you guys do in the mental health space.

I also -- I want to give a special thank you to NAMI. I worked recently with

NAMI-NYC, with Kim Blair and the rest of your folks, about educating our constituents around 988. So my questions will be a little bit in line with 988, but also some of the mental health proposals that are in the Governor's Executive Budget proposal.

So the first question I had -- and this could be for any of the panelists -- deals with the discharge of patients who are struggling with mental health issues. So you'll see a revolving door of individuals that go in and out of the care system. I'll give you one recent example. Folks might have heard of the police-involved shooting that took place in Edgemere yesterday in the Rockaways. And an individual who was shot and killed by police was an individual who was reportedly, and stuff is still coming in, a regular at our local hospital, in and out.

So I'm just wondering -- the $7 million that the Governor has proposed in her Executive Budget, how that could be used to help those individuals, those types of patients -- and obviously we don't have all

the details of that type of patient -- but those types of patients to be able to access long-term care and services.

And then my second question is, how helpful will the Governor's $100,000 investment in maternal care for the 988 hotline be, for all of your organizations? And anyone can take a pick at this.

MR. SHAPIRO: I'll just jump in and answer your 988 question first, Assemblyman.

Again, thank you for all the work that you've done to promote 988 and to make sure your constituents know what it is and that it's different from 911, you know.

Again, the policy experts at NAMI national have already kind of deemed that New York's 988 system is the most equitable in the country. We've had the most statutes in place to ensure equity in reporting on it.

And to take it this extra step -- again, you know, Senator Brouk has done so much to shed light on maternal mental health issues. And I think those are -- we talked

about how things -- mental health issues are stigmatized; I think these are even more stigmatized. For a new mother to admit that they have these feelings is very difficult.

And letting people know that they can anonymously call 988 and talk about these issues, they won't be judged and, you know, they'll get some resolution, is tremendously beneficial. So very excited about that new option. And again, you know, we do hope that it's still kind of being implemented, that it is going to divert more people away from the criminal justice system. You know, the commissioner said less than 3 percent of the 988 calls result in 911 calls. So very positive momentum in that direction.

ASSEMBLYMAN ANDERSON: And just really quickly, if anybody can give me the answer -- thank you for that -- for the last 20 seconds I have, on the revolving door for the individuals who -- you?

MR. LIEBMAN: Just from my end, you know, the administration talked about -- the commissioner talked about Critical Time

Intervention programs, which are outreach programs that immediately upon discharge from a hospital -- even actually previous to discharge from a hospital -- there's a planning process in place which is necessary.

ASSEMBLYMAN ANDERSON: Thank you so much. My time has expired.

Thank you, Madam Chair.

SENATOR BROUK: From the Senate side, we'll now have Senator Canzoneri-Fitzpatrick.

SENATOR CANZONERI-FITZPATRICK: Thank you. Thank you, everybody, for testifying here today. Appreciate it.

My understanding is the cost of opioid use disorder medications in every county jail far outweighs the appropriate state funding, and the majority of counties receive approximately $160,000 per year in state aid to support these programs, which includes clinical supports. Many counties have supplemented the lack of state funds with Opioid Settlement dollars in order to maintain compliance with the state law. And yes, I was reading from your statement.

So my question regarding this is, how has this impacted local governments, since they're now diverting funds away from other programs to this issue? And what do you see as a possible solution? Should we be increasing funding?

MS. DAVID: Sure, yes. So I think in my testimony I asked for additional funding from the state side to support these programs.

The conference did a study back I believe in 2018 that initially said, you know, there was a certain amount of funding that was needed just on the clinical support side to push some services into the jails for individuals with substance use disorder. It was never fully funded. I think we asked for about 12.7 million when it first kicked off; we received 3.75 million. And then as the time increased, then we also had the medication-assisted treatment mandate that went in to make sure that all available medications were available to anyone in the jails.

So because of the cost of those medications, the cost went significantly higher. So while we have -- our original ask for just supports was 12.7, you know, five years ago, and now we're at 8.8, which we fully appreciate the state funding us at a higher level. But in order to sustain the cost of those medications as well as those clinical supports that are needed to coincide with those, yes, a lot more money would be needed on the state side to help really expand and make sure that those medications aren't draining other resources -- county tax levy, Opioid Settlement funds.

SENATOR CANZONERI-FITZPATRICK: And then as far as -- and I know my time is short. Has there been coordination between the state and NAMI regarding their best practices and trying to make sure that we're not reinventing the wheel every time we're trying to address an issue.

MR. SHAPIRO: Yeah, thank you, Senator.

We do talk to the staff at OMH

regularly and, you know, give our suggestions, especially on key things like the expansion of mental health courts, the admission and discharge program, the transition teams. So yeah, we have certainly an open communication pipeline to OMH.

SENATOR CANZONERI-FITZPATRICK: Thank you very much.

MR. SHAPIRO: Thank you.

CHAIRWOMAN WEINSTEIN: We go to Assemblywoman Kelles.

ASSEMBLYWOMAN KELLES: Thank you all so much. I appreciate it deeply.

A million questions; I'll talk to you about some of them afterwards. But one question I have, we've talked about the COLA not being a pay raise, it's simply in real dollars to prevent a pay cut, which we've noticed that that is not the case. So essentially, in real dollars, we've had a pay cut over the last 10 years.

So just wanted to make that really clear. So what is the impact on our workforce? So can you talk a little bit

about the vacancies that you see in the institutional setting and, you know, in the nonprofit world?

MR. LIEBMAN: Yeah, and especially in the nonprofit world. Because we have double competition, in the sense that we not only have competition with, you know, the manufacturing sector, the Amazons and the McDonald's, et cetera, et cetera, but we also have the state-operated issues as well. The state -- I think it was talked about earlier, state-operated programs, they get higher salaries than nonprofits do.

ASSEMBLYWOMAN KELLES: So you lose to them.

MR. LIEBMAN: They get a pension -- which is another issue for another time.

But the bottom line is is that we lose out on everybody. You know? So we are the -- you know, people are doing it -- and I said this earlier, people are doing it because they really believe in the work.

ASSEMBLYWOMAN KELLES: So we definitely need parity and pension.

What are the actual percentages that you're seeing in vacancy rates now in the nonprofit sector?

MR. LIEBMAN: It's hard to say. Again, I would say that what we generally have is about 25 to 30 percent on a yearly basis, which is brutal --

(Overtalk.)

ASSEMBLYWOMAN KELLES: -- that's tough enough. We are saying that we are lacking in mental health, it's the biggest crisis of our time, and then we know we need and we're 25 percent short of what we actually need? That in and of itself answers that.

But I did -- we can follow up, but that is -- that is the number I wanted on record because it's so important. So thank you.

MR. LIEBMAN: Sure.

ASSEMBLYWOMAN KELLES: I did want to get to the competency restoration services that you --

MS. DAVID: Sure.

ASSEMBLYWOMAN KELLES: Can you talk

about -- well, first of all, having a mental health and wellness court system throughout every county that would redirect people into comprehensive mental health services, would that be a help to this issue?

And are what you're saying with competency restoration services that they are only being provided short-term, acute, but not actually addressing the issue? Is that basically fundamentally what you're saying?

MS. DAVID: Yes. And it's a very complicated issue to get out in three minutes, so --

(Laughter.)

ASSEMBLYWOMAN KELLES: Exactly.

MS. DAVID: So yes. I mean, ultimately, you know, the competency restoration services are very limited services that are supposed to bring someone back to be restored, to be able to understand the charges brought against them. Right? So they are not long -- they're not supposed to be long-term mental health treatment.

The facilities that these individuals

are in are not conducive to long-term appropriate mental health treatment. But we are seeing that they are not -- you know, they're languishing in these facilities for long periods of time.

ASSEMBLYWOMAN KELLES: Do you think promoting or ensuring that we have a mental health and wellness court in every county redirecting people into comprehensive mental health services would address some of this instead of putting them in jail?

MS. DAVID: So it would -- I can follow up with you.

CHAIRWOMAN WEINSTEIN: If you'd answer that to the committee as a whole, in writing.

MS. DAVID: Yeah.

CHAIRWOMAN WEINSTEIN: We next go to Assemblywoman Chandler-Waterman.

ASSEMBLYWOMAN CHANDLER-WATERMAN: Thank you, Chair. And thank you for the work that you all are doing right here in the mental health space.

I want to shout out NAMI, working with my AD for the mental health task force within

my district. We partnered on and -- for Caucus Weekend, on 988 and the challenges and how we can improve. So thank you for that.

I'll start with Mr. Shapiro, then I'll have a question for you, Mr. Liebman.

Can you please offer any strategies and specific recommendations on how the state can reform hospital admissions and discharge planning?

And two, as we know, there are incarcerated people living with mental health conditions who are currently in prison, jails, and many of them are Black and brown. Jails and prisons, as we know, are not a therapeutic setting for people to recover. And when people transition back into the community, there isn't enough community support, resources -- and to add, there is a high recidivism rate with the population.

So what can we do in our roles as legislators to ensure that justice-involved individuals have an opportunity to get care and not jail or prison time by our mental health courts?

So those are two, sorry.

MR. SHAPIRO: All right. I'm going to try to be quick so you can get to Glenn. I'm going to try to keep it to a minute.

So for admission, I mean, again, we want to make sure people look for ways to admit people and not divert them. Right? And admit them properly, and look at their full case history. And again, especially if people have been coming in and out of hospitals. You know, I use my mom as an example. I know she was discharged too early, was back in a month later. Right? But they never looked at what happened a month ago and why she was discharged too early or things that might have failed the patient in the past.

So, you know, a few years ago we introduced something called Nicole's Law that was going to look into these issues, and the state has kind of run with it, which we appreciate, in looking at -- you know, again, looking at someone's full case history and don't repeat things that have failed them in

the past as far as admissions, and really making sure you're getting person-centered care, which is so important.

And as far as discharge, again, someone shouldn't have to wait weeks to get connected to a community provider. They should be connected before discharge, with their medication, and they know where they're going to continue their recovery in the community. That's what's so important.

I want to make sure I give Glenn time.

MR. LIEBMAN: Thank you very much.

ASSEMBLYWOMAN C HANDER-WATERMAN: Thank you. Yes.

MR. LIEBMAN: And just my response is around the justice-involved population. The 1115 waiver, which just came out last month, there was supposed to be -- we were anticipating that there was going to be, as part of the waiver, this 30-day window in which individuals, before they were released from prison, would have 30 days prior to make sure they got all their services in place, make sure they were Medicaid-billable,

everything was Medicaid-billable so the second they walked out the door they would get those services.

Unfortunately, it was not in the 1115 waiver. Now we're hearing that it might be in another waiver. But right now that is an opportunity that we really lost here. Can you imagine just if people knew, 30 days in advance, that they could link with a -- the second upon discharge, get their medication, link with a provider, link for housing -- it would be, you know, a game-changer.

ASSEMBLYWOMAN C HANDER-WATERMAN: Thank you so much.

MR. LIEBMAN: Yup.

CHAIRWOMAN WEINSTEIN: Assemblywoman Giglio.

ASSEMBLYWOMAN GIGLIO: Hi. Thank you all for being here today. Thank you, Madam Chair.

So my question is dealing with Stony Brook University and when law enforcement is picking up people that they think may need a psychiatric evaluation and

they're bringing them to Stony Brook University Hospital, and they're having to hold that bed for them until they can find a place for them to go for a 30-day program.

And then I'm hearing from the people in the 30-day program that when they let them out, they go back to the places that they were in and they sometimes come back again.

So I want to know what your solution to the problem is, if you could fill me in, please. Thank you.

MR. LIEBMAN: Well, first of all, you know, we have to invest in the system. You don't want to say money's the answer to everything, but it is incredibly important.

You know, I went through all the years, as did Assemblymember Kelles, all the years we didn't get any funding. So if we were able to, you know, where we're looking to propose this whole notion of getting a $500 million investment into mental health -- because you're absolutely right.

And it's going to -- unless we have that kind of funding in place for the

community-based programs, then you're going to see this cyclical nature of what you're facing, what this individual faces at Stony Brook every day, because there's not enough placement for them. There's not enough programs for them. There's not enough services, support or housing for them.

And this is something that we have to change. Hopefully -- again, the Governor's got this vision; hopefully that will help change. But the reality is we need a lot more to make those investments happen.

ASSEMBLYWOMAN GIGLIO: Yeah, another thing that's also happening is that when they do get out of the 30-day program, they are -- an appointment is made for them to go and talk to a psychiatrist or to somebody, a sociologist, that would be able to help them. And they're not going.

So what happens to those people, and what can we do to make sure that they make those appointments, that they're taking their medications so that they're not repeating the same cycle?

MR. LIEBMAN: I think that the outreach is obviously key. I talked about the critical intervention programs. I also think that there are the community ACT teams, the sort of community treatment teams that are dealing with those who are hardest to serve in the community.

We have to -- again, there is this whole movement around creating more and more of them -- which is great clinically, and a great idea, and we totally support it -- but you don't have the staff to be able to hire these people to bring them on.

ASSEMBLYWOMAN GIGLIO: And if you don't have access to transportation.

So have you identified areas where people are living or where they're coming from that a central location might be necessary for either group meetings or something to require them to go? Because they're really taxing the hospital system, and the hospitals need those beds.

MR. LIEBMAN: Yeah, it's a -- what you have to do -- it's not just me, you have to

identify hotspots across the different areas in the communities, and you say, these are the places -- you look at those, and these are the places where we clearly have the most issues with people coming in and out of the hospital, and we have to make sure that we emphasize that area and put a lot more funding, a lot more staffing into those areas.

ASSEMBLYWOMAN GIGLIO: Okay, I'll look forward to your map as to where those areas are.

(Laughter.)

ASSEMBLYWOMAN GIGLIO: Thank you.

MR. LIEBMAN: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Burdick.

ASSEMBLYMAN BURDICK: Thank you for your testimony.

And this is a question for Mr. Liebman, Mental Health Association. And I saw in your testimony that you're working to try to develop a pipeline for career and mental health --

MR. LIEBMAN: Yes.

ASSEMBLYMAN BURDICK: And that with respect to OMH, that there was a provision in the budget -- it didn't get through because of opposition from professional associations that you tried to address. Can you tell me what that opposition is and how you're trying to address it and where it stands and how we might help?

MR. LIEBMAN: Well, thank you very much for that. And actually Assemblymember Gunther has a bill out about the qualified mental health associate title.

So that's the title that OMH developed last year. And it didn't get through the budget because I think, you know, a lot of the clinical programs were very upset that it was going to infringe on their scope of practice. So, you know, the social workers were very concerned, the psychologists, psychiatrists, very concerned that these qualified mental health associates would really, you know, infringe on that scope.

So we, as the Mental Health

Association, have been working with the Office of Mental Health to say how do we divide and say which of the services that are not going to impact clinically at all -- because there is a need for those paraprofessionals to come into our field.

ASSEMBLYMAN BURDICK: So is it in the -- a section of budget now, or is there any conversation at this point to --

MR. LIEBMAN: No, there is not. And again, we're talking -- you know, the Office of Mental Health wants to be in response, because they like the idea, but there's nothing that we've seen in the Executive Budget in it.

But we're talking about it because we think it should be a policy.

ASSEMBLYMAN BURDICK: So -- but OMH is amenable to it, is that correct?

MR. LIEBMAN: They are very amenable to it. We're having good conversations with them because they recognize, Assemblyman, that paraprofessionals, 18-year-olds who are graduating high school, looking for careers,

they don't necessarily want to be clinicians --

ASSEMBLYMAN BURDICK: So are you allaying any concern at the association?

MR. LIEBMAN: We've talked to the associations, and we're just, again, making sure that they understand that the last thing we want to do is infringe on clinical practice, that these people can be helpful to you and not be, you know, an impediment.

ASSEMBLYMAN BURDICK: I'd be interested in talking with you offline on it.

MR. LIEBMAN: I would love to.

ASSEMBLYMAN BURDICK: Thanks so much.

MR. LIEBMAN: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

So now I'm going to try and channel Assemblywoman Gunther.

(Laughter.)

CHAIRWOMAN WEINSTEIN: Glenn, the two questions that there wasn't time to answer before: How would a pension system help the mental health workforce? And then, secondly, what is your organization's role in mental

health first aid training statewide?

MR. LIEBMAN: Well, thank you for those questions.

First of all, I don't think a pension would help at all, so don't -- don't -- no, of course I'm kidding.

(Laughter.)

MR. LIEBMAN: You know, look back at the 1920s when Governor Al Smith was here. He created a pension system for the city and the state and the county workers. Then in the last 50 years we've had police and firefighters and teachers who have all gotten a pension, appropriately. We totally support that. And it's not a great pension anymore, we know that. We totally support that.

But the reality is we have 800,000 people in our community workforce. We're not just talking mental health, I'm talking across the board -- 800,000 people who, when they retire, when they leave, guess what their benefit is? See you around. Maybe they have some sort of small, you know -- some sort of small funding, but the reality

is they're not going to get anything. They're really not -- you know, and our ability to be able to give them a retirement and a pension system would be huge.

So we don't know how much that would cost, frankly. We know it's well deserved, because these people are working very hard. We know it would certainly help with retention. We don't know how much it will cost. So that's why we have this study bill in place that Assemblymember Gunther has introduced to find out, to bring together three of the major agencies to find out the cost of that.

And alongside that, we also have -- we're working with Cornell University to study the survey results that we've put together. So they're going to put out a report about the impact also.

So in terms of mental health first aid and youth mental health first aid and teen mental health first aid, you know, Commissioner Sullivan referenced teen mental health first aid as a really -- as a strong

adjunct to the engagement with peers around mental health support and services. That's essential. And we really have to have youth mental health first aid with those individuals, those agencies, just so they -- you know, the front-facing agencies and the schools, just so they have an understanding what mental health first aid is.

It's just a teaching. It's an education. It's an eight-hour training that can really give people a sense of what mental health services are about and end the stigma and, frankly, respond to the crisis as well. So ...

(Inaudible legislator comment.)

MR. LIEBMAN: You're certified? There we go, that's great.

SENATOR BROUK: Wonderful.

I want to thank our panelists so much. That is the end of your questioning.

MULTIPLE PANELISTS: Thank you. Thank you, Senator.

SENATOR BROUK: Take care.

Next we'll call up Panel C. So we

have New York Disability Advocates; Families Together in New York; Citizens' Committee for Children of New York; New York State Coalition for Children's Behavioral Health; and the JCCA.

All right, everyone is situated. It's a big panel. So we will start with Mike Alvaro, president, for New York Disability Advocates.

MR. ALVARO: Good afternoon. Thank you very much for having us here.

I'm with New York Disability Advocates. That's a statewide coalition of providers. We have over 350 providers, and that is six associations: IAC, the New York Alliance, New York Emerging and Multicultural Providers, The Arc of New York, DDAWNY and where my day job is, CP State.

And I'm going to be repetitive. We have needs. We have gotten a group together, and we have come together on our ask. And our ask is pretty simple. We need a COLA, the 3.2 percent that you've been talking about. It functions as a Medicaid rate. We

have had more than a decade of cuts and no investment in our system. And the recent COLAs have been helpful, but they don't make up for where we were.

When we do have a COLA -- and I think it's important when you hear some of the other testimony today -- the 5.4 percent COLA was used, created a 7.2 percent increase in salaries that the providers got the funds and created and reinvested in their workforce. So we need not a 1.5 percent COLA, but we need the full COLA. We are losing ground, and we need to make sure that we bring the field back up to where it was back many years ago.

We also need a direct support wage enhancement. Senator Mannion was talking about the bill that he and Assemblymember Seawright have. We are looking for that $4,000 investment. We need not just to have our organizations be brought up to a certain point, but we need to make sure that the staff in our field are brought to a living wage. That $4,000 investment will do that.

We've had vacancy rates -- the crisis in the workforce has been significant. We've had vacancy rates right now of about 17 percent, but we've been as high as 30 percent. What has happened is that the investment in our workforce has made a difference, but we are still at significant levels of shortages and staff crisis levels across the state.

These are not minimum-wage jobs. They are not home care, and we do not receive the benefit of home care. We need to keep the separation from minimum-wage jobs and the jobs that are in this field.

Right now, 44 percent of our folks have a college degree. Our DSPs, we have 110,000 statewide -- 70 percent are women; 65 percent are Black, Asian or Latino. Yet 80 percent of those folks make less than $20 an hour. There's an imbalance between the skills needed and the compensation they receive.

We've conducted a survey, the Miami-Ohio survey that included 4500 DSPs,

and we found that 85 percent like their job. And of those folks that like their job, one in four are not satisfied with their pay. Which makes it very difficult to keep them.

So I'll be really quick. We need the 3.2 percent and an investment in our workforce.

SENATOR BROUK: Thank you.

Next up, Paige Pierce, CEO of Families Together in New York.

MS. PIERCE: Thank you. Thanks, chairmen and committee members, for taking the opportunity to listen to us.

I'm Paige Pierce. I'm the CEO of Families Together in New York State. We represent the voice of families and young people involved in multiple systems, primarily mental health. But as you heard earlier when Assemblymember Walsh talked about -- read that email from a parent from her district, how frustrating it is as a family member to not be able to access the kinds of services and to really try to navigate a system that's unnavigable and not

really a system at all.

We are an organization that represents the voices of families, and we are family members. I'm a parent of a child who was diagnosed with autism when he was three years old, and he's now 32. So the navigating part is -- we are peers. We have that lived experience so we have the ability to be able to help -- our philosophy is "nothing about us without us." We can help you all do your jobs and better create policies that will be effective because you listen to us as stakeholders.

One of the things that was really frustrating about hearing that email from Assemblywoman Walsh was that this is -- she gets those emails, you all get those emails. We get those emails and phone calls every single day from family members who are trying to navigate what we call a system of care but is really not. We have a quote from a family member from Long Island who says: "We have a great behavioral health system on paper. I've never experienced it, but I'm told it's

there."

You know, I think that's really telling about -- what we're trying to communicate to you all is that the multiple systems that are siloed are not effective when they work with the walls up between them. We need more coordination and collaboration, and we need more family and youth involvement in order to be able to do it right.

You know, Governor Hochul, I've got to give her credit for the emphasis on mental health, and particularly children's mental health, in both her State of the State and in the budget. It is like no other Governor has ever done. We used to joke about if we could get the Governor to mention children or families in their State of the State, it would be a miracle -- and then mental health and children and families was monumental.

And we do appreciate the attention being paid, and the investments being created. But there is still a lot to be done.

The rising demand -- you can see in my testimony -- I'm not going to go over all the testimony, but the bulleted areas that are our priorities at Families Together, the rising demand and eroding capacity -- we know that the needs have gotten stronger, particularly with the pandemic, for behavioral health services, particularly for children and families. And the demand is there, and the resources need to be able to reach that same demand.

The rest of it's in my written testimony.

SENATOR BROUK: Thank you. Fabulous.

Next we'll go to Ronald Richter, CEO of JCCA.

MR. RICHTER: Thank you so much.

And good afternoon, Chairs and members of the Senate and Assembly. I'm Ron Richter; I'm the CEO of JCCA and have previously served as New York City's ACS commissioner and a judge of the Family Court.

So you know, JCCA is a child and family services agency. We work with about

17,000 children and families a year, providing a continuum of behavioral health, preventive and foster care and residential services. Our work sits at the intersection of child welfare and behavioral health. So when one of your colleagues asked this morning of the commissioner of Mental Health about how that agency is supporting foster children, JCCA is here to say that there are serious silos between the Office of Children and Family Services, which licenses foster care and residential, and the Office of Mental Health, which is responsible for the well-being of children and families, especially those that have experienced a separation because of foster care and, of course, for some reason a judge decided they couldn't live with their family.

I want to just emphasize I support the COLA, I think it's critical. We have significant turnover at JCCA in all of our frontline positions. They are difficult to fill. I appreciate your acknowledgement in your comments today of how important that is.

We also need to look carefully at Medicaid rates for child and family treatment support services, for health homes, and for home- and community-based services. The Governor proposes a cut in health homes. The only way you can get the highest-end community-based service in New York, under our current rules, is if you're in a health home. So how the Governor proposes to cut health homes -- while services we provide require one -- suggests that there's a disconnect or perhaps another way to get these services. But unless that exists, we're really cutting off children that need the highest level of care.

The last thing I just want to emphasize is my agency, because of the challenges OPWDD has in building capacity, takes care of children that are 22 and 23. They're young adults, they're not children. We are not licensed to do so. Because we are not licensed to do so, the state's agreements with MCOs do not require MCOs to pay for health and behavioral health services for

kids who are 22 and 23 and in foster care or residential.

So our agency eats over a million dollars a year because we still provide the health and the behavioral health. I urge the Legislature to think about how agencies like mine can support a Medicaid program with no Medicaid dollars.

Thank you so much for your concern.

SENATOR BROUK: Thank you.

Next we'll go to Maria Cristalli, board chair for the New York State Coalition for Children's Behavioral Health.

MS. CRISTALLI: Well, good afternoon and thank you, Chairs Brouk, Weinstein, Gunther and members of the Assembly and Senate. Thank you so very much.

I'm Maria Cristalli. I serve as president and CEO of Hillside and as the board chair of the New York State Coalition for Children's Behavioral Health. The coalition represents 43 member organizations that serve approximately 200,000 individuals each year and employ over 14,000 staff.

We are pleased -- I agree with my colleagues that the Governor has repeatedly talked about and created action around the mental health investments that we need. In fact, today, listening to Commissioner Sullivan standing up new programming two years in a row with ACT teams, investment in school-based mental health, crisis services, standing up beds -- all very good. But what we're looking for in terms of a system is a sustainable behavioral health system for children.

What do I mean? The Governor said during her address "Our children need much help," and they do. And all of the testimony today reinforced that need. Building on some of the areas to focus on, health homes serving children. Approximately 30,000 children and families receive health home care management. We strongly oppose the cut that is proposed in the Executive Budget and ask you to restore that.

Let me share a few data points on why this is important. For those children, a

68 percent increase in primary care visits. That's helpful. ER visits, a decrease by 12 percent. This program is working for individuals in the behavioral health system. And at least 80 percent of those children have one mental health diagnosis.

Very important when we think about the front end of that system and the connection to the service array that's part of Medicaid managed care -- the Child and Family Treatment Support Services and the home and community-based waiver services, that $195 million ask for sustaining that system is critical to the future of behavioral health.

I want to also emphasize the support for the 3.2 percent COLA and suggest a multi-prong approach. We need that COLA year after year, but we need investments like the Community Mental Health Loan Repayment Program. Thanks to the Governor for including that in the appropriation for child-serving staff and agencies.

But also let's think about scholarship

programs, so we can help elevate people in our field, people of color and women that are interested in progressing into clinical roles and leadership roles.

Thank you.

SENATOR BROUK: Thank you so much.

And finally we have Jennifer March, executive director for the Citizens' Committee for Children of New York.

MS. MARCH: Hi. Thank you for having me. I'm Jennifer March, the executive director of Citizens' Committee for Children. We're a child advocacy organization based in New York City, but we do statewide advocacy.

And today I'm really here on behalf of the Healthy Minds, Healthy Kids Campaign, which is a statewide campaign of clinical practitioners, caregivers, youth and people working across the State of New York to actually address the behavioral crisis that children and families are facing.

I want to, because time is of the essence, talk really about what's not in this budget and what we hope that you can

consider. The Healthy Minds, Healthy Kids campaign undertook a Medicaid rate study that examined rates of reimbursement for Article 31 and Article 32 services, children's Home and Community Based Services, and Child and Family Treatment and Support Services, and we really examined these rates to try to uncover what would enable the outpatient behavioral health system to expand the urgent needs that they're seeing, so that we can actually confront waitlists, address wait times, shore up the workforce, prevent the cycling of children in and out of hospitals, and ultimately avoid the need for crisis intervention.

And we found four things. First is rates of reimbursement must keep pace with inflation every year. That is not debatable.

Second, we need to establish a care team coordination fee. These providers are responsible for coordinating with a growing array of care managers because children and families touch many different systems, and they should be compensated for the time it

takes to do so. That would cost about $20 million.

Three, we need to adjust children's clinic rates to reflect the extra effort and expertise of serving children. Children live in families. Clinicians must actually interact with many, many people in the households, and this rate study suggests that we need a 35 percent rate enhancement for clinic visits provided to children. That would cost $117 million.

And fourth, we need to address the CFTSS and children's HCBS rates to acknowledge that we never achieved the volume efficiencies that were anticipated when Medicaid redesign was established, and frankly the providers of service in this area are subsidizing state rates in order to continue to provide these services at the community level. So an increase in rates for CFTSS and HCBS would cost another $44 million.

That's a $195 million ask. It would result in 1300 more clinicians in the field

and allow us to serve 26,000 more children. And I really applaud Senator Brouk and Assemblymember Gunther for helping us in championing these recommendations.

Thank you.

SENATOR BROUK: Thank you to all our panelists.

To start on the Senate side, we will have Senator Mannion.

SENATOR MANNION: Thank you. Thank you all for your work in these fields. It's greatly appreciated.

Three minutes. Ronald, you mentioned that lack of coverage with the MCOs. Is there -- is a legislative fix possible, and is there any active legislation that would make that change?

MR. RICHTER: I don't believe there is. But I do think that there could be a legislative fix, namely that MCOs are required to pay for behavioral health and health services until a child is -- or a young person is discharged.

Most of our young people on our campus

in Westchester -- we have right now somewhere around 25 young people that are 22 or 23, and we're providing those services.

The answer is yes, I think there is a solution. No, there is no legislation.

SENATOR MANNION: We'll keep that conversation going, then, if you could contact our office.

MR. RICHTER: Absolutely. And thank you very much.

SENATOR MANNION: Mike, thank you for making the distinction between home care and direct care, and we'll continue to have that conversation.

And I sat up here for a workforce hearing where someone testified that many years ago, when they worked as a DSP, the minimum wage was $2.75. They received $5. That's what drew them into the profession.

That leads me to my question, which is you have seen a decrease in the number of vacancies. Do you attribute that to -- would number one on the list be because of the wage increases that have been provided over the

last couple of years?

MR. ALVARO: Yes, I think that personally probably that is the biggest driver.

But that doesn't resolve the issue of the discrepancy between the level of the minimum wage and where we are as a field. Right now we're very close to the minimum wage, and the state-operated facilities doing the exact same work are making a lot more money for the same amount. Let me just give you a couple of them right here. That the workers who are starting in downstate that work in the voluntary sector are making $17, or $34,000 a year, and the state-operated are making $55,000 a year.

In upstate, state-operated are making $50,000 a year, and starting salaries are $33,000 a year.

So those differences are so significant. Yes, we've gotten the number down, but the fluctuation is still there and we're still spending over $100 million a year in the churn because we aren't able to keep

the staff on board.

SENATOR MANNION: Agreed. We need a set-apart from minimum wage.

And Maria, can you tell me about your retention rates in the first year of your staff?

(Pause.)

CHAIRWOMAN WEINSTEIN: Assemblywoman Sea --

MS. CRISTALLI: Sorry, I'm playing with the mic here.

They are, Senator Mannion, 57 percent. So we are churning 43 percent of new hires after only one year. It's astounding. And it's expensive.

SENATOR MANNION: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you. Sorry.

Assemblywoman Seawright.

ASSEMBLYWOMAN SEAWRIGHT: Thank you to this distinguished panel for all of your testimonies.

I'd like to direct my question to the NYDA president, Mike Alvaro.

What's the outlook for provider agencies under the proposed Executive COLA of 1.5 percent?

MR. ALVARO: We -- the COLA is really important for things like insurance. We all live in the world today, right? The insurances alone we're seeing anywhere from a 20 to 30 percent increase across our agencies. That alone, the 1.5 percent doesn't cover.

We aren't really able to maintain operations. So the 1.5 percent really is not going to keep up with the day-to-day operations and the money needed to keep our doors open. We fall further behind.

ASSEMBLYWOMAN SEAWRIGHT: Thank you.

SENATOR BROUK: Next we'll have, on the Senate side, Senator Webb.

SENATOR WEBB: Thank you all so much for being here.

My question is specifically for you, Maria, with regards to youth Assertive Community Treatment teams. And so I know that there's a $9.6 million increase in

funding for the creation of 12 additional youth Assertive Community Treatment, or ACT teams statewide.

And my question is, where will these 12 new programs be located? And has the pandemic stunted the progress of these programs?

MS. CRISTALLI: Thank you, Senator. And I'll have to get back to you on where they will be located.

I will tell you, in terms of standing up these programs and my organization and my colleagues -- my organization, we personally have three programs. They have been difficult to stand up, especially in rural areas, because of the time commitment, the crisis component of the program, and the shortage of clinicians in our sector. That Community Mental Health Loan Repayment program will help. It's not the only thing. Getting back to the COLA, you know, we have to have incentives, sign-on bonuses.

We as an organization -- I know my colleagues have done the same -- keep raising

compensation. Compensation has become a year-long sport because we need to attract the people to do so.

I'm very pleased that the Office of Mental Health, Commissioner Sullivan, has heard the feedback from providers on how difficult it has been in standing up youth ACT teams, has lowered the capacity per team, cost-neutral adjustments. And also the option to utilize crisis -- the crisis component of that work in a different way with OMH approval.

For example, my organization, we have 24/7 clinicians that staff and serve the community, and they're able to help the youth ACT teams.

Thank you.

SENATOR WEBB: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblywoman Gunther.

ASSEMBLYWOMAN GUNTHER: I'm okay.

CHAIRWOMAN WEINSTEIN: Assemblywoman Giglio.

ASSEMBLYWOMAN GIGLIO: Good afternoon.

Thank you all, and thank you for your advocacy.

So we know that there's no shortage of people that are seeking assistance as parents age out and are trying to get their family members or children into programs. But we know that there is a shortage with the DSPs. And from what I'm being told is that the increase from the 1.5 percent to the 3.2 percent would be $50.8 million. Fifty-point-eight million. And the wage enhancements would be another 125 million.

Budgets are about priorities. And it's a small price to take care of our most vulnerable population. And I urge my colleagues, as they have done in the past years that I've been here, to continue their advocating and their voice being heard in the budget process, to make sure that 3.2 percent of a COLA increase is the minimum.

So now my question for you is, when you do find somebody that may want to become a direct support professional -- and you talk about the turnover, which is extremely high;

43 percent is just really unfathomable. But there is a big turnover. And the wages seem to be the -- requirement for the wages to do this kind of work keeps going up. They want more money to do this kind of work.

So what do you suggest we do in order better train or provide incentives through SUNY/CUNY programs, so that people are interested in pursuing this career, perhaps with a career beyond, like moving into the nursing industry from coming out of being a DSP in a home setting, and then getting a college education at the same time. Any suggestions?

MS. CRISTALLI: Well, I'll start. I think earning and learning is important. So for this segment of our workforce, they have to have the opportunity to continue working while they're earning, whether it be a credential, going on to complete their education. So it does have to be a multi-prong approach that applies not only the adjustments in salary and benefits, but also the opportunity for scholarships for

them to go back to school while they're working.

Many of the -- and I'll speak for myself, my organization. The DSPs, they have other jobs, whether it be an assignment within our organization, outside our sector, to make ends meet. So I think we have to provide incentives like that, multi-prong-approach ways to even subsidize what they might need to be successful. Like childcare, for example. It is a complex solution.

ASSEMBLYWOMAN GIGLIO: It is, because they're paying for education; meanwhile they're collecting a smaller salary than what someone would be in pursuing a career in healthcare.

So thank you.

MS. CRISTALLI: Thank you.

SENATOR BROUK: Thank you.

Now we'll have Senator Canzoneri-Fitzpatrick.

SENATOR CANZONERI-FITZPATRICK: Thank you, Chair.

Thank you for everybody being here. I

especially like the list that we got of priorities.

There are a number of things that I've heard in the testimony that are so troubling. The fact that there is such an increase in youth that are making a suicide plan and actually trying to attempt suicide is just so heartbreaking. And one of the things that I read in your testimony, Ms. Cristalli, about half of New York's youth with major depressive episodes in the past year, did not receive treatment at all.

And one of the things that I've talked about is changing the narrative to say that we should be talking about mental wellness so that our youth are not stigmatized as to the fact that they need help. Right? We tell them, go to the doctor when you have a stomach ache or a headache, but to feel depressed, we don't somehow have that narrative yet.

So my question, though, to you, because you're the experts and not me, is how do we change that? How do we get more kids

to ask for help? What are we doing wrong? And I know that there's a shortage of the people that are actually giving them the care, and the COLA increase certainly will hopefully help them. But certainly looking at the fact that there's only 28 child psychiatrists per 100 children is just so troubling.

And I've often said I would love to be able to say give a professional who wants to get that extra education -- that's where we give them a loan forgiveness. Because let them serve in a community-based program or serve underserved communities where we really need it, and give them the benefit of those -- that free education.

But I really would like to open it to anybody. What are we doing, what can we do better to get our youth to ask for help?

MR. RICHTER: Well, I'll say that I think that it is important to integrate mental health services into schools, and I applaud the Governor for that. But there are costs associated with getting those started.

As you're very aware, many of our schools don't have space for a janitor's closet let alone a mental health clinic.

So I think that while it's a phenomenal proposal that does address some of what you're saying, on the ground it's extremely difficult to make happen. The more that those services are there, the more people are going to talk about how it's okay, you know. But it's few and far between.

MS. MARCH: And I would just add quickly we did the rate study to identify concrete, pragmatic solutions so that children and families get services timely. Because the worst thing you can do is make someone wait weeks and months, because then there is a disconnection from the very thing that could be lifesaving.

SENATOR CANZONERI-FITZPATRICK: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman Eachus.

ASSEMBLYMAN EACHUS: Thank you, Madam Chair.

I apologize for not being here for most of your testimony and all. But please know that I am very aware of all the needs you have. If you recall, I've said in past years I have a daughter who's 37 years old who since birth has been involved with the Office of Mental Health and all of the various different programs.

You mentioned about how difficult it is to get into schools. These clinics that they're talking about, and the fact that there is no room, that is true. I'm from the Hudson Valley. That's true in the Hudson Valley, as it is all over.

And that's why I actually have started a discussion with Commissioner Sullivan about opening up a wing of a hospital that has been closed, and then making that a reception center, evaluation center for all of the school districts in the area. You have the physical facility already, and then all we would have to do is staff it properly.

And of course it also wouldn't take the kids out of -- which is what the idea is

here -- out of their community to get evaluation, to receive services and so on like that. So there are some other things.

I am going to ask one way out of the ballpark question, because I notice that you all deal with children and families and so on like that. And the question I have is, is, in any of your programs, there an active program to get the parents to sign up for guardianship for their kids? Because that's so important.

I can tell you it makes a big difference when they're older, you know, past 18, on the type of services that they can actually receive, because the parents can still stay involved with those kids and so on like that. So do we, in any place or anywhere, encourage guardianship?

MS. PIERCE: Most of the people on this panel specifically work with families and children with behavioral health, mental health needs more than developmental disabilities. And we do have -- you know, our hope always for our young people is that

they will be their own self-advocates and that they will be independent.

So we're not as involved in that kind of guardianship kind of thing as people in the developmental disabilities community might be. And that's why I ask if you might want to --

MR. ALVARO: Absolutely. So we do have guardianship programs where we work with families to make sure that they are involved. So I thought you were talking about --

(Overtalk.)

ASSEMBLYMAN EACHUS: Let me tell you something. It's not just developmental disabilities. It also applies to mental disabilities. And that's why -- and of course that guardianship does not have to be expressed, even it it's signed up for. But if you don't sign up for it, that child, if it's necessary, needs guidance when they're older, may not get it if the parent does not have guardianship.

So I think it's very essential.

MS. MARCH: I wonder too if healthcare

proxy could be pursued, as an alternative path which allows you to have permission to be involved in healthcare decisions.

ASSEMBLYMAN EACHUS: Sure. Thank you.

SENATOR BROUK: All right, so I'm up next on the Senate side.

And first I have to say thank you all for everything you do.

Paige, I've used your slogan, "Nothing about us without us," in so many instances because it's so, so true.

And obviously, Maria, great to have other Rochesterians here with us.

So I won't -- I wish I could belabor the point, but I only have three minutes. So I won't belabor -- you know, we've talked about the $195 million investment, we've talked about what that means. Jennifer, thank you for walking through that.

I do want to ask, because I think that you all particularly, as a panel, have so many stories and experiences, because this is your everyday. Right? And I think one of you said it, we get a few emails and calls

about what families are going through -- that's your everyday. And it's multiple families, it's hundreds and thousands of families.

So I would like to just take a minute to hear from you a little bit more about the waitlists that we hear about. If someone wants to take it to describe exactly what families are looking at in terms of looking for services for their children, in terms of waiting times.

MR. RICHTER: I can say that in addition to the waiting times -- and then I'll pass it off to Paige -- it takes a long time to get approvals from insurance companies for certain services. So once a child is in a health home and has care management, you have to apply to get approval for HCBS services or the like. And we lose a lot of families while they're waiting for whether they get approval or not. And then there's a waitlist.

SENATOR BROUK: Can you give us a time -- I mean, are we talking days, weeks,

months, average?

MR. RICHTER: It can be a couple of months.

SENATOR BROUK: Okay, thank you. Just for that piece.

MR. RICHTER: Yeah, for that part.

MS. PIERCE: And I'm just going to talk really briefly and then hand it over to Jennifer to talk about the Healthy Minds, Healthy Kids study.

But, you know, we hear stories of families whose kids are in ERs for months, months, living in an ER. Just entirely inappropriate. And mostly it's because of the lack of availability for -- it's because of the waitlists elsewhere.

So I just wanted to share that and then let Jen talk about the study.

MS. MARCH: Well, we're actively trying to ascertain like concrete waitlist data both from OMH and providers. But we know it can range from -- anything from several weeks to several months.

SENATOR BROUK: And within that time

period, I have to imagine the needs get more complex.

MS. MARCH: Correct.

SENATOR BROUK: And when you're talking -- I mean, you said months. To be a child in an emergency department? I mean, that's a complete retraumatization, I would imagine. And then you're probably dealing with even more than you were originally.

MS. PIERCE: And I just want to point out also for those who are sort of the bean-counters or, you know, more thinking about the financial impact, the impact on the parents -- imagine if your child is in the ER for months. How are you supposed to go to work? How are you supposed to make a living? Your employer is then suffering as well.

SENATOR BROUK: Thank you.

CHAIRWOMAN WEINSTEIN: To close questioning for this panel, Assemblywoman Kelles.

ASSEMBLYWOMAN KELLES: Just so I can clarify my questions, do any of you work with developmental disabilities, or is --

MR. RICHTER: Our agency does have a program. They're child-welfare-involved young people, in our case.

ASSEMBLYWOMAN KELLES: Okay. So I just want to share -- I had an experience this weekend that I'm still processing, and so I'm going to share a couple of points and then I have a question for you.

Five families, all with children who have been classified as permanently disabled, severely disabled. They are distraught to an extreme because they cannot get any services for any reason. So I just wanted to share some of the things that they said that are just absolutely broken.

Providers don't get paid for time spent billing, writing reports, literally only the minutes that they spend with the individual.

There's a new Medicaid system that they're now being asked to do, and they had another one they just did three years ago. So many of them are dropping out because it's like literally the last straw.

Annual Medicaid renewal applications for Medicaid --

MR. RICHTER: You might have been speaking to one of us.

(Laughter.)

ASSEMBLYWOMAN KELLES: So the application process has to be done annually. I'm going to try and yell it out.

The Medicaid renewal application annual -- it's 32 pages, it changes the order of the questions every year. It doesn't align with OPWDD, so they have to do the same application for every single department that they work with, which is usually three or four of them.

They also talked about guardianship process costs a lot of money, impossible to access.

Here's the last one. They have a critical nursing shortage. Parents recruit someone, and to bill Medicaid the nurse needs to register in the Medicaid system as a vendor. This process takes 60 to 120 days before she can bill. By that time, this

woman had already found another job because she literally couldn't bill for any of her services.

In tears, frustrated about all the nuanced systems -- I didn't even read through the whole list.

Can you talk about the red tape that you are seeing consistently across the board like this, how you would like us to help? Because this is costing us an insane amount of money, extra money that it doesn't need to.

MS. CRISTALLI: I'm going to jump in in one area, thank you very much. And I think that it is related to services through the managed care plans.

And for providers like my organization, certainly we're on, and our colleagues that are contracting with 10 or 12 managed care plans -- all the processes that you're describing, credentialing, the contract process, paperwork, are all done a little bit differently. So if we can standardize as much as possible and say,

here's a standard of how we're going to do these things -- because we do want the majority of time doing the work with young people and families.

That's one concrete suggestion.

MR. RICHTER: Yeah, I mean, administrative fees -- you know, we have created essentially a hospital setting at a social services agency which includes having people to deal with insurance companies that generally deny claims. So we now have a staff that we are not paid to have in order to capture Medicaid money.

ASSEMBLYWOMAN KELLES: Let's connect after this. Love to get these solutions. Thank you so much.

CHAIRWOMAN WEINSTEIN: Thank you.

SENATOR BROUK: That wraps up all our questions. Thank you so much to our panelists.

MULTIPLE PANELISTS: Thank you.

SENATOR BROUK: Next, we're going to start Panel D. We have the Drug Policy Alliance; Coalition of Medication-Assisted

Treatment Providers and Advocates; Alliance for Rights and Recovery; Licensed Creative Arts Therapists; and the New York Alliance for Inclusion and Innovation.

Welcome, everyone. We will start with Toni Smith, New York State director for the Drug Policy Alliance.

MS. SMITH: (Mic off; inaudible.)

SENATOR BROUK: You need to turn your mic on.

MS. SMITH: It's -- very close, okay.

My name is Toni Smith. I'm the New York State director at the Drug Policy Alliance, the leading organization in the United States promoting drug policy that is grounded in science, compassion, health, and human rights.

It has taken decades to undo just some of the harms of mass criminalization and the drug war. And now, in the midst of really a record-breaking overdose crisis, we are concerned that we are seeing a change in response to drug use from a public health concern to once again a criminal legal system

concern. We cannot recreate the Rockefeller Drug Laws.

DPA is urging the Legislature to omit Part U of the Health and Mental Hygiene Article VII language, which proposes scheduling many new substances. We urge this for a number of evidence-based reasons.

First, scheduling does not reduce overdose deaths. Criminalization has been the default response to the drug market for decades, in which time the drug supply has become more adulterated and overdose deaths have skyrocketed. This is because the criminalization of the drug supply results in the introduction of new adulterants, which are often more potent and unpredictable.

Second, criminalization amplifies the risk of fatal overdoses. A 2023 study of drug seizures and overdoses found that drug busts were associated with almost a 24 percent increase in opioid overdose deaths.

Third, scheduling undermines drug checking. New York State recently launched

drug-checking programs across the state. Embedded in harm-reduction programs, drug checking creates an important feedback loop between providers and consumers. By understanding what and why consumers are using, providers can relay a more nuanced understanding of the drug supply to public health officials, which is critical to informing our public health response.

To be most effective, community members need to know that knowing what's in their drugs is not going to be used to criminalize them.

Fourth, scheduling hinders lifesaving research. Some of the most important medications developed to address the crisis are the result of research on opioid-related substances such as naloxone.

Part U proposes to add, to Schedule I, more fentanyl analogs, five benzodiazepines -- which are only temporarily placed on the federal schedule -- and proposes to add xylazine as a Schedule III drug, even though it is not federally

scheduled.

We need more research, not criminalization. It is still unclear, for example, how effective naloxone is in responding to xylazine-involved overdoses, so research is key. Instead of criminalization, you can pass legislation to ground drug checking in health by protecting participants from punishment and criminalization and you can expand overdose prevention centers. The state does have the authority and the resources to expand OPCs.

DPA commends the work of the Opioid Settlement Fund Advisory Board for their recommendations and their work, echoing their recommendation to use settlement funds for OPCs. And we urge the Legislature to do the same. At this time, we can save lives or we can criminalize, but we cannot do both.

Thank you.

SENATOR BROUK: Thank you so much.

Next we have Allegra Schorr, president of the coalition of Medication-Assisted Treatment Providers and advocates.

MS. SCHORR: Good afternoon. My name is Allegra Schorr. Thank you for the opportunity to testify today on behalf of COMPA. COMPA represents medication-assisted treatment providers and the opioid treatment programs across New York State.

The New York State Overdose Death Dashboard shows overdose deaths increased by 73 percent from 2018 to 2022. And during the same time period, overdose deaths connected to illicit fentanyl increased by 127 percent. And furthermore, while overdose deaths for all racial and ethnic groups grew, Black and Latino/Latina New Yorkers had the highest overdose deaths and the largest increase in rate from 2021 to 2022.

We need immediate action. But the Executive Budget proposes a 13.4 percent decrease to the OASAS budget. A renewed sense of urgency and investment is needed to combat the current opioid crisis. We need to increase access to treatment, but how?

Adding more and more program sites in the middle of a workforce crisis creates more

of a workforce staffing shortage, as existing programs struggle to retain staff and compete to recruit staff.

Moreover, we keep seeking to add programs while our communities are watching an increase in fentanyl use and homelessness, and then they blame the syringes they see on the street and the blight they are experiencing on our existing programs.

Increasing access is more than starting a lot of new programs. We need to address the insurance reforms so that whatever coverage you have is how you can access treatment. We need to pivot from criminalization to public health. We need to work with our communities to defeat NIMBY.

We need to increase reimbursement, and we need to ensure that commercial reimbursement is at least equal to Medicaid. We need to tie the COLA to the Consumer Price Index to recruit and retain our workforce.

We need to invest in career development. We need to reform the OMIG's audit practices so they pursue actual fraud

and abuse and stop taking money back from providers who have actually delivered services. And there are opportunities to do this in the budget.

We can reduce the cost of toxicology testing. We can make the Opioid Stewardship Fund permanent. We must capture savings from managed care and reinvestment in the system. And we must remember that the cost of overdose is high. The economic costs are staggering, but the human cost is incalculable.

Thank you. Thank you for all your work on this.

SENATOR BROUK: Thank you.

Next we have Harvey Rosenthal, CEO of Alliance for Rights and Recovery.

MR. ROSENTHAL: Good morning -- good afternoon, and thank you.

In my three minutes, I hope to be able to offer some specific recommendations to some of the key questions that have been asked around what we can do to help people manage their health in ways that prevent

avoidable ER, hospital, jail and prison stays and, if they end up there, what we can do to break the cycle.

I'm Harvey Rosenthal, person in long-term recovery, CEO for 30 years of the Alliance of -- of the New York State Association of Psych Rehab Services and now the Alliance for Rights and Recovery.

I've got plenty of comments in my testimony, but I want to say the people that I represent are people who are called having serious and persistent mental illness, complex conditions, hard to serve, people on Medicaid. A number of them are people of color, and a number of them are justice-involved.

And my folks first wanted me to tell you the great sense of alarm and outrage they feel about the onerous direction in which discussions and some mental health policies have been going in New York City and New York State. Yes, we've seen a tremendous increase in violence of all kinds, but we are not the cause by any means, we're not the cause of

that violence. Four percent of violence in our community. You would not know that if you read the newspapers -- and now even the New York Times, I just have to say that out loud.

But there is a narrow focus here in our answers -- traumatizing hospitalizations, medications that may have side effects or don't work, and coercion. Now we're rebuilding beds on the same hospital grounds we were trying to, you know, move into the community about.

There are people saying we don't have a -- they don't have a right to live in the community if they don't take treatment, they don't have a right to live in the community.

Some people want to place more people with outpatient treatment orders -- I'm sorry, I'm trying too hard to get it in. But if you notice on Kendra's Law, the outpatient commitment law, which we're so against, both the Times and the Comptroller found that these programs are not working. People are not getting to the services.

And imagine if you don't have a court order, you're really not getting to the services. So it's really about connectivity, and we'll talk about that a little bit if we have time.

Remember, also, if we're going to do a study, which we're doing now, four out of five AOT orders in New York City, three out of five statewide, are leveled at people of color. Why is that?

There's some new legislation out you may hear about, Assembly 812, Senate 5508. We ask you to reject it: More coercion.

We know a lot more of what works to engage people. Okay, prevention. Mrs. Gunther really funded a pilot which we made really into a national model. It's called INSET. It engages people who meet every criteria for Kendra's Law but are engaged voluntarily by peers, 80 percent at a time. The state is doing that; we need more of those.

We need to divert people from avoidable emergency room visits. We have

stabilization centers, but they're only a one-day program. We need more peer crisis respite programs that can last eight to 28 days. Oh, my goodness.

AMT providers, from Daniel's Law. We need alternatives to police. We need a Peer Bridger -- just give me one second.

SENATOR BROUK: I have to cut you off now, Harvey.

MR. ROSENTHAL: A peer bridger is a person that will help you leave the state hospital and stay out of it and won't come back --

SENATOR BROUK: Thank you.

MR. ROSENTHAL: -- and won't pass you on to somebody else but will stay with you. It's a great model. I'll tell you more later if we get a chance.

SENATOR BROUK: Thank you. Okay. Well, I'm sure someone will ask about all of those things at some point, and we'll hear more.

I do want to get to Drena Fagen, Licensed Creative Arts Therapists.

MS. FAGEN: Hi. I'm so glad to be here. I am testifying on behalf of the Licensed Creative Arts Therapy Advocacy Coalition.

For those of you -- I think many of you are already familiar with us. The license is Licensed Creative Arts Therapists; sometimes, for short, we're called LCATs. So I might slip and call us that sometimes, so you'll know what I'm talking about.

I'm representing over 2,000 already licensed legally practicing psychotherapists who work in New York State. We are licensed by New York State. The rules for how we were licensed were created by the state.

We are -- I've been in the mental health sector for almost 20 years as a licensed clinical social worker and a licensed creative arts therapist.

We can all agree universally all day long that there is a shortage of psychotherapists for children, teens and adults, and there's a shortage of jobs -- or psychotherapists to take jobs at clinics and

hospitals and all these other facilities. This is a crisis. There is a very high demand for workers and clinicians, and there is a very high demand by consumers for therapists to get them off those waiting lists.

So I'm going to be a real exception today; we are not asking for money. Are you ready? We are asking for language to be added to this budget that will help fix the problems that people have been talking about all day.

There are -- a couple of days ago there were 2,116 licensed creative arts therapists who are licensed in this state to practice psychotherapy, to bill insurance using procedure codes that are identical to clinical social workers, mental health counselors, and marriage and family therapists. There are 2,116 of us who could take these jobs and who could help people if you add language to the budget that says that we can be added to the Medicaid provider list. That's it.

So I'll tell you a little bit about creative arts therapists, if you don't know, in particular related to the things of today. We are specialized, we have specialized training that makes us different from the other mental health counselors. We have expertise in working with children in particular who are developmentally more responsive to play and creative arts interventions in conjunction with evidence-based and best practice therapy models that everybody uses, and we use as well.

We are also well trained to work with anxious, depressed and school-avoidant teens. Highly reluctant participants in therapy do very well with nonverbal activity-based therapies that again are grounded in psychotherapy principles that all the other practitioners are using. We are very effective with nonverbal disabilities and culturally aligned with immigrants who might find talk therapy stigmatizing.

Thank you.

SENATOR BROUK: Thank you so much.

And finally we'll hear from Michael Seereiter, president and CEO, New York Alliance for Inclusion and Innovation.

MR. SEEREITER: Thank you. Good afternoon.

My name is Michael Seereiter, with the New York Alliance for Inclusion and Innovation. We're also a member of the coalition Mike Alvaro spoke about earlier, New York Disability Advocates.

Over the past two years the CPIU has increased 13.9 percent. Governor Hochul has proposed during that time a 7.9 percent increase. And while that's a significant improvement over her predecessor, it's nothing to be proud of.

Thanks to the Legislature, that has been increased to 9.4 percent, but remains 4.5 percent below what was needed simply to maintain the status quo for all human services, including our OPWDD services and programs.

And now the Governor is proposing to

continue that underfunding by 50 percent with a CPIU that's at 3.2 percent and a 1.5 percent COLA. Let's make no mistake about this. Our deplorable 17 percent vacancy rate and 35 percent turnover rates are directly attributable to almost 15 years' worth of shortchanging provider organizations who use those resources primarily to fund their workforce, to compensate their workforce.

The very least that the state can do is not perpetuate this and fully fund the 3.2 percent COLA this year. And to make reparations for those years in which there was no COLA, we ask you to fund the $4,000 direct support wage enhancement so that we can begin bringing compensation for direct support professionals closer to what it should be to reflect the complexity of their work.

New York State has historically failed to demonstrate the political willpower to fund OPWDD and other human services as they were originally designed decades ago. Now,

simultaneously, OPWDD has failed to evolve, to provide flexibility to use the limited resources that we do have more effectively. And you now have an antiquated system that is completely unstable and at high risk of collapse.

Commissioner Neifeld's efforts to partner with stakeholders and pursue reform of OPWDD are the most genuine and significant that I have seen in my 25 years of doing this. But the combination of the Governor's lack of commitment to address OPWDD's priority number one -- the workforce -- and the intransigence of OPWDD and its resistance to change, is too much to expect one individual leader to overcome.

So I'm left with a quote from Dorothy Day: "Our problems stem from our acceptance of this filthy, rotten system."

It is time for the Legislature to initiate a comprehensive redesign of supports and services for New Yorkers with intellectual and developmental disabilities. While we ask you to stabilize the system with

a COLA and the direct support wage enhancement, we also ask you to establish a blue-ribbon commission to reimagine and redesign a system that will be sustainable to support New Yorkers with intellectual and developmental disabilities for the next 50 years.

Thank you.

SENATOR BROUK: Thank you so much.

We will start on the Senate side with three minutes for Senator Fernandez.

SENATOR FERNANDEZ: Okay. I thought I had more time.

Well, really quick, thank you so much for being here. I'm really sorry that there wasn't more availability for additional advocates to testify today, because we know there are so many of you and the work that you do is really immeasurable.

But I want to go back to the scheduling topic while we have a few minutes. It's been -- oh, I can tell from the work that I've done, the conversations that I've had, our communities are desperate to see

drugs off our streets because of the terrible things that we've seen come of them. And scheduling is always quick to be assumed to be a solution because we're going to get it off.

Could you please go into it further about how harmful scheduling can be and how it restricts research?

MS. SMITH: Sure, thanks.

So interestingly, when the federal government themselves even schedules, announces that they're scheduling new substances, in the justification they will often say we are scheduling this because the last scheduling created new substances to enter the market.

And so as we are struggling to catch up, our health responses are struggling to catch up with understanding xylazine and understanding new analogs and understanding the best way to treat wounds and other symptomology that people are experiencing, the drug supply is changing faster than we can respond.

And so it is tempting to want to do something quickly to stop a substance. But, one, the scheduling doesn't remove the substance that's scheduled, and it also incentivizes the creation of new -- new substances that are often more potent and less --

SENATOR FERNANDEZ: I think that should be repeated. It incentivizes the creation of new substances, right?

MS. SMITH: Yeah. It does, right, like the --

SENATOR FERNANDEZ: And then we're going to have another drug out on the market, like xylazine, that could be causing worse if not the same harm.

MS. SMITH: Yeah.

SENATOR FERNANDEZ: Thank you for that.

I also want to ask about peer support services. It's my understanding that it is not something reimbursable. Could you speak about the importance of peer support services and maybe why we need to? You, Harvey.

MR. ROSENTHAL: Great question. Peer support is not adequately reimbursable under Medicaid. The state plan does not pay for that. So there's so much lost opportunity to be able to deploy peers. OMH is trying to pay for them too in the rehab option for clinics, but they're needed everywhere and there's not enough funding to -- at hospitals and emergency rooms and jails and prisons there's not the range of funding streams we need.

SENATOR FERNANDEZ: And a peer is somebody with experience, lived experience.

MR. ROSENTHAL: Like me, a person in long-term mental health recovery.

SENATOR FERNANDEZ: Thank you.

I have 28 seconds. OPCs, that has not been discussed today. The bill that is in existence by Senator Rivera -- he was here today -- is not the idea that is fearmongered out there. It specifically allows current needle-exchange programs to allow for an OPC.

Could you speak about the need about that -- or for that?

MS. SMITH: Sure. We have two in New York, the only two in the country. They've been operating without interference for over two years. In those two years they have intervened in over 1300 overdoses successfully.

And Rhode Island, Massachusetts, Minnesota are all on their way to authorizing or have already authorized overdose prevention centers, and New York is being left behind.

SENATOR BROUK: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: We go to Assemblywoman Gunther.

ASSEMBLYWOMAN GUNTHER: Harvey, how are you? I haven't seen you in a long time. Good to see you.

MR. ROSENTHAL: You too.

ASSEMBLYWOMAN GUNTHER: Can you speak about the benefits of the Peer Bridger and crisis -- those programs?

MR. ROSENTHAL: Thank you.

So I wanted to say that to

Assemblywoman Giglio, who was asking these questions. When someone's in the hospital, what we do now is we force them out quickly, without supports, and they just return.

We created a Peer Bridger model in 1993. It's very prescribed. It starts in admission, goes all the way through discharge and nine months thereafter. We're not handing off to people. That trust is really important. We stay with you until you're really engaged, and we work with you on housing, peer support, wellness, you know, and relapse prevention.

It's a fabulous program. It's replicated around the country. So that's the Peer Bridger program. And right now, we would love to see -- and if you're going to bring up new hospitals and put all that money in them, and they're going to be discharged in that same poor way, there should be a Peer Bridger program in every hospital.

ASSEMBLYWOMAN GUNTHER: Okay, what about -- I want to talk about Kendra's Law and voluntary programs. What's going on with

that?

MR. ROSENTHAL: Well, the INSET program that you funded -- it's done amazingly -- is a national standard now. And again, it's -- in order to get in the program you have to meet every criteria for Kendra's Law --

ASSEMBLYWOMAN GUNTHER: I'm talking about the study, like the study --

MR. ROSENTHAL: Yes. Yes. We have a study that actually the Assembly encouraged us to put in that will look at, again, scientifically, at whether people are getting better because of better services or the forced treatment. There's a real controversy. We're looking for that study to really examine that and, also, the overuse of, you know, people of color in forced treatment.

ASSEMBLYWOMAN GUNTHER: I was interested in your, I don't know, the psychotherapists and the crisis. I've never heard of that before, and I was very interested in that. And, you know, how --

I've been using it for a long time, I just never heard of it.

MS. FAGEN: So psychotherapy is the term that's used in --

ASSEMBLYWOMAN GUNTHER: Well, I know psychotherapy, but --

MS. FAGEN: Right. Right. So we're one of the four licensed -- creative arts therapists are one of the four mental health practitioner licenses that were created in 2006 under Article 163. So we're just one of the four. I mean, to put it simply, each of those professions has slight distinctions and differences between each other, but fundamentally we're all doing diagnosis, we're all doing treatment planning and assessment, and we're providing psychotherapy to clients with mental health needs.

In a variety of settings -- in OMH settings, in inpatient, in Article 31 and 32 clinics, in substance abuse facilities, IOPs. And I run a large private practice that serves the Hudson Valley and Brooklyn, in Williamsburg, Brooklyn.

So we've been around for the exact same amount of time, almost 18 years now, and -- yeah. So yeah. And it's a little bit of an uphill battle for us because people aren't always exactly sure who we are and what we are. But it's -- we are actually the second largest of the mental health practitioners, 14 percent.

ASSEMBLYWOMAN GUNTHER: I'll have to talk to you after this.

MS. FAGEN: Sure, okay. Sure.

ASSEMBLYWOMAN GUNTHER: Interesting.

SENATOR BROUK: All right, next we will go to Senator Canzoneri-Fitzpatrick.

SENATOR CANZONERI-FITZPATRICK: Thank you, Chair.

And thank you to everybody on the panel for what you're doing.

Ms. Fagen, I'm intrigued by what you've presented to us about --

MS. FAGEN: The no money part?

SENATOR CANZONERI-FITZPATRICK: -- creative arts therapists, and I hope that we'll be able to take your recommendation and

incorporate more of that since we have such a workforce shortage.

And I do want to just say we've been talking about it all day, about the COLA increase and the challenges that you have in your workforce, and I really sympathize with you trying to get a job done.

My questions are limited because of time. Mr. Seereiter, I wanted to ask you about something you put in your statement about artificial intelligence and what we can do for people with intellectual and developmental disabilities. Could you describe to us why -- how you would use that?

MR. SEEREITER: First of all, you need to put some pretty significant parameters in place in terms of the rules of what's allowed and what's not allowed. But after that, I think it presents some really interesting opportunities to take away, if you will, some of the mundane, more routine aspects of service delivery that occupy an inordinate amount of time for the direct support professionals that we hire.

I'm going to guess, taking a guess here, 25 to 30 percent of their time on a day-to-day basis is occupied with activities that don't really have an awful lot to do with what people receiving services and their families want.

But the artificial intelligence can also be used to start to really push the boundaries, if you will, in terms of how we use technology to support people to live more independently. We've seen great opportunities already with little pilot projects, if you will, to support people who have lived in a, for example, certified residence, to then live on their own with the use of technology. Remote supports provided by a direct support professional, who is supporting five or 10 or 15 people in their own homes and can be called at a moment's notice and can show up at a residence, at an apartment, within five minutes.

There are lots of these opportunities, and I think we should be looking to see how the technology can augment the opportunity to

support us to provide services and supports for a population of people that we're struggling to do so with the population of staff who we're able to attract to these jobs.

And quite frankly, I think it also then creates more opportunity to push more of the resources back into the compensation for those staff who do the work.

SENATOR CANZONERI-FITZPATRICK: Yeah, I wasn't quite sure how you would use it. Certainly going through therapy with AI, I didn't think that was what you were proposing, so I appreciate you clarifying it.

MR. SEEREITER: We've seen some remarkable things where AI-empowered robots are engaging with individuals on the autism spectrum who have never spoken with a human being in their life. It's stunning stuff.

SENATOR CANZONERI-FITZPATRICK: Okay. Well, that's very interesting to hear.

I just had a general question. I know that Zoom and other technology, remote

technologies, have been used quite a bit during COVID in every aspect of our life. Is it still permitted to be used for services? And do you find that that's helping you reach more patients?

MR. SEEREITER: Me?

SENATOR CANZONERI-FITZPATRICK: That would be great if you could --

MR. SEEREITER: I'm happy to answer it. Yes, we do have some permissions on that. We really need to expand it and look to extend to utilize the technology to the fullest extent. We clearly started that process in the pandemic. I think we need to continue it.

SENATOR CANZONERI-FITZPATRICK: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Brown.

ASSEMBLYMAN KEITH BROWN: Thank you, Chair.

Mr. Se-reeder --

MR. SEEREITER: See-reiter.

ASSEMBLYMAN KEITH BROWN: Seereiter,

thank you.

I want to talk to you about your comment about a blue-ribbon panel, and I want to talk to you about parity. It seems to me that one of the best ways to fix the system is fix the funding, the commercial health insurance paying 50 percent on the dollar of what Medicaid and Medicare will pay.

So what do you see, you know, if we were to create a blue-ribbon panel, first of all, what agencies would we include? I have an idea. And what issues would you tackle under that?

MR. SEEREITER: The blue-ribbon commission that we're envisioning is one really focused on the OPWDD system. I'm sure that there are plenty of opportunities for my colleagues to be weighing in on other systems that deserve that attention as well.

When we're talking about OPWDD services, we have defined the system and defined the way in which we -- I'm going to put big air quotes around it -- assure quality in such a way that it is all

compliance-based. It has zero to do with how people receiving services and their families -- what they want and how they want those supports provided.

We need to move our system towards something that's much more focused on outcomes, defined by people who are receiving services and their families. What are those valued outcomes? We need to be moving in that space in a very significant way, which would then allow us to free ourselves from some of these compliance-based activities that occupy an inordinate amount of time of the direct support staff that we can attract and engage and retain in our programs.

This is the kind of thing I think we really need to think about, because at least as I see on the horizon, I don't see any major changes happening in terms of the ability to recruit and retain for us to be able to compete with jobs that are paying $25 and $30 an hour. We're going to need to get to that level or we're going to need to comprehensively redesign the way in which we

envision services for people with disabilities.

ASSEMBLYMAN KEITH BROWN: Thank you very much.

MR. SEEREITER: Sure. My pleasure.

ASSEMBLYMAN KEITH BROWN: Thank you, Chair.

SENATOR BROUK: Okay, next we will have Senator Webb.

SENATOR WEBB: Thank you all for being here.

I just have two questions, one with respect to the Executive's proposal to cut the OASAS budget by 13.4 percent. And so I know that there's a renewed sense of urgency and investment needed to combat the opioid crisis. So this question is specifically for you, President Allegra.

What would this funding go to specifically? So that's one question.

And then my next question picks up where my colleague Senator Canzoneri-Fitzpatrick asked a question around AI and helping those with special needs. I

know there's been a lot of concerns around AI, especially as it pertains to potential ethical implications and how we can protect the public. And so my question is, would there -- or would there need to be things we need to do to address potential ethical concerns for individuals with special needs?

MS. SCHORR: Thank you for the question, Senator.

I think that looking specifically at the budget slides that OASAS presented, the bulk of the cut looks as though it goes to the Aid to Localities.

But just taking a step back from there, I think one of the big issues that we have is that the OASAS budget is really designed to be broad-based and will really support services across everybody in the state. There does seem to be some -- an emphasis on Opioid Settlement dollars, which as you heard earlier this morning from the commissioner, great work, of course, and we're certainly appreciative of those -- of that funding. But they were always intended

to be really based in innovative projects and not really meant to be ongoing kind of funding.

So that it really is apples and oranges, and we want to make sure that that -- that those OASAS funds go fully across and continue to support -- and that those dollars get where they need to be.

MR. SEEREITER: On AI, as I said before, I think we need to really establish some ground rules about what's appropriate and not appropriate in terms of the use of technology to support people. That needs to be key.

One of the things that's become very clear to me is that if we're not part of the conversation, we will become the victims of that conversation. We need to be engaged in that discussion about what's going to be appropriate and not, what's in bounds and what's out of bounds, clearly defining that. And that's going to be very difficult for many of us who are, you know, challenged with some of these technologies.

But a set of guiding principles that we at least as a sector can adopt, if you will, that the state can consider using as a set of rules to say this is what's allowable and what's not allowable. But you need to engage in the conversation. Otherwise, it will get done to us in some capacity or another.

SENATOR WEBB: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblywoman Simon.

ASSEMBLYWOMAN SIMON: Thank you all for your testimony.

Mr. Rosenthal, I wanted to ask you -- or explore with you a little bit the programming you've done, but also, you know, this Daniel's Law which we are proposing, first responders not be law enforcement but actually properly trained people, and follow that model of the Cahoots model from -- I think it's Oregon, right?

How familiar are you with that? How is that consistent with the work that you've done? Or not.

MR. ROSENTHAL: Well, I think it's -- you know, we -- we're part of the Daniel's Law Coalition, and we work very closely with the Senator on that. It's a key piece of diversion from the criminal justice system. It's an avoidable arrest, it's an avoidable incarceration, by sending a mental health worker who knows how to respond, rather than a police officer who may not.

We used to spend a lot of time training police officers, a lot of turnover. It's not always a fit. Peers and EMTs are the way to go. That model really works.

ASSEMBLYWOMAN SIMON: Thank you.

And Ms. Fagen, I could have sworn in last year's budget we got the LCATs back in.

MS. FAGEN: We did have support in the Assembly and the Senate to put them back in, but it didn't happen.

ASSEMBLYWOMAN SIMON: Okay, so it didn't happen in the final analysis.

MS. FAGEN: So we're back.

ASSEMBLYWOMAN SIMON: Because I've been working with the Brooklyn Conservatory

of Music and their therapists, music therapists, who are the same license, right?

MS. FAGEN: Right. Yeah, they have an esteemed program that brings music therapy specifically to schools all across Brooklyn particularly, right, and I think even probably beyond. Yeah.

ASSEMBLYWOMAN SIMON: Okay, great.

So I apologize for that. Hopefully we can get that happening, because it's really important.

MS. FAGEN: Yeah, thank you.

ASSEMBLYWOMAN SIMON: Thank you.

SENATOR BROUK: Okay, so I guess I'm up.

I first want to thank all of you for all the work that you do. I think the passion for your work comes out in your testimony, and it's certainly noted.

Just to pick up where my Assemblymember colleague left off, looking at the licensed creative arts therapists. So I just want to make sure that these numbers -- I have these right. You said you were the

second or third biggest group of folks -- what was the statistic?

MS. FAGEN: We're the second-largest of the mental health practitioners.

SENATOR BROUK: Second largest. And how many --

MS. FAGEN: Right. So social workers -- which I am also a social worker -- it's no contest. There's like 50,000 of them. But in terms of the mental health practitioners, the first one is the licensed mental health counselors, there's around 11,000. We're the second ones, just over -- a bit over 2,000. Licensed marriage and family therapists, who are Medicaid-covered, are below us. And the licensed psychoanalysts. So that's the pecking order.

SENATOR BROUK: And you're the one that's not able to be a Medicaid provider.

MS. FAGEN: And the licensed psychoanalysts also, both of us.

SENATOR BROUK: Today we're talking about you.

MS. FAGEN: Yeah, yeah, I know. But,

I mean -- you know.

But the thing is, just to speak on that, we care about increasing the services, right? And if there's these two licensed professions, right -- I care about us, but also why are they not here? Like why are we not --

SENATOR BROUK: It doesn't seem logical.

MS. FAGEN: It doesn't seem logical.

SENATOR BROUK: So we're going to try again.

(Laughter.)

SENATOR BROUK: But I think, you know, we've talked about the workforce issue, and right now we're literally looking at, as we sit up here on this dais, looking at potential providers for folks who aren't able to reach every person who needs help simply because of something we could change here in Albany. So I appreciate you kind of hammering that home.

In my last minute and 27 seconds I'm coming to you, Harvey, to talk about -- you

mentioned the INSET program, you talked about diversion programs. You had some very interesting statistics in terms of the success rate for some of these programs that are peer-led as opposed to law enforcement-led. And I would love for you to dig deeper on that and whatever other notes you had to share with us.

MR. ROSENTHAL: Oh, thank you.

Well, I know the CAHOOTS program, on which Daniel's Law is based, is 30 years of data in proving that very few people have to get involved with the police.

The INSET program engages 83 percent of people who otherwise everybody thinks are unengageable and would be on an order. The Peer Bridger program has reduced recidivism by between 40 and 70 percent in state and local hospitals through this model I mentioned earlier.

I do want to say one thing. When people leave a hospital, they need three things: A person to support them, a Peer Bridger; a place to live that will accept

them -- Housing First, not only a housing program, housing that takes you even if you're symptomatic or using; and a place to go, a clubhouse, for example. So a Bridger, Housing First, and a clubhouse.

SENATOR BROUK: And you believe programs that would include those three things would be much more successful at taking individuals who have severe mental illness when they're being discharged from hospitals, to keep them out of perhaps the carceral system --

MR. ROSENTHAL: That will break the cycle.

SENATOR BROUK: -- or keeping them off the street without the care that they need as well. Okay, thank you.

MR. ROSENTHAL: Thank you, Senator.

CHAIRWOMAN WEINSTEIN: We go to Assemblywoman Seawright.

ASSEMBLYWOMAN SEAWRIGHT: Thank you to the panel for your testimony.

I'd like to direct my question to President Seereiter. You mentioned in your

testimony your partnership with the McSilver Institute for Poverty Policy Research at NYU. Can you expand on the findings of the report and how you're partnering with OPWDD on the $30 million statewide DSP recruitment campaign to assist providers with finding new staff?

MR. SEEREITER: I can do a bit of that, and I can also share the report with you as well.

We've been working in collaboration with OPWDD to provide technical assistance to the provider organizations as they try to recruit and retain direct support professionals. And what we did was essentially an organizational self-assessment of those organizations throughout the state, all provider organizations, and we also matched that up with a survey of direct support professionals so that we could identify where there are likenesses and where there are differences in the perception about what's working well and what's not working well.

We're now using that experience and that data to drive specific technical assistance in the remaining time using those ARPA dollars to drive specific technical assistance to provider organizations to help them up their game. We've got some pretty interesting findings from that. Probably a better use of time would be to share the report with you and you can peruse it, and I'd be happy to answer questions later on.

ASSEMBLYWOMAN SEAWRIGHT: Great. Thank you very much for all your work.

MR. SEEREITER: Thank you.

CHAIRWOMAN WEINSTEIN: So next we go to Assemblywoman Kelles.

ASSEMBLYWOMAN KELLES: I really appreciate all of you being here and taking the time and your patience.

A ton of thoughts, and I'd love to hear your feedback. One -- I have three, so let's see how fast we can do this. The peer support programs, Harvey, that you were just talking about, I have heard from some colleagues and something that concerns me is

the belief that they -- that peer support programs use people who are not qualified and you should only use people who have certifications and therefore, you know, these programs don't work.

Can you respond to that?

MR. ROSENTHAL: It's absurd.

(Laughter.)

ASSEMBLYWOMAN KELLES: Thank you. It's on record.

MR. ROSENTHAL: But also peers are certified in New York through the OMH Academy of Peer Services.

ASSEMBLYWOMAN KELLES: Thank you.

MR. ROSENTHAL: They're heavily trained. My Bridgers are trained in numerous -- and they have certificates in peer wellness coach, peer bridging, you know, all kinds of training and competency.

ASSEMBLYWOMAN KELLES: So they're educated, trained, qualified and they have trust, inherently.

MR. ROSENTHAL: They deserve better pay, too. Yup.

ASSEMBLYWOMAN KELLES: Just want that on record. Okay, cost-effective.

MR. ROSENTHAL: Thank you for that.

ASSEMBLYWOMAN KELLES: With respect to -- this is for Toni of the Drug Policy Alliance. I'm curious, I've been seeing stigma about just drugs in general skyrocketing -- going in the wrong direction, for some reason, over the last couple of years. Making it harder for OASAS, for example, to have their clinics in communities for people to access.

Tons of stigma for people. I have a bill, for example, that would bring -- that people could bring their drugs to a clinic to find out whether or not it's laced with something so that they don't overdose, and also provide the opportunity for treatment at those centers. The political ability to even talk about it in this environment -- can you talk about what changes we need, education, to be able to --

MS. SCHORR: I think you just said it. Education is really like the key word there.

And we're doing frankly not enough, not a good job. And I think there's enormous -- I think people in communities, you know, people understand this is something that affects everybody everywhere. And, you know, there's that thing where, you know, you have people stand up, do you know someone, does somebody -- that when you have people stand up in a room, basically the whole room is left standing. Because everybody knows somebody who is affected by addiction. It affects everybody everywhere.

And yet when it comes down to on my block, in my world, you know -- and I said it in the testimony, it's always I don't necessarily want to see this here, and it's because -- it's not because -- it's not because of the treatment, it's not because of what is actually working, it's because they're seeing something else and they're confusing them. They think it's the people that are in treatment that are causing the problems. But that's never true. And if you were to take a magic wand and remove all the

treatment centers, you would not solve any of the problems that they're seeing.

ASSEMBLYWOMAN KELLES: Yeah. One of the things I just --

MS. SCHORR: It might make them worse.

ASSEMBLYWOMAN KELLES: -- want to note, a comment in the last five seconds is I keep hearing from all of you the lack of funding that we're putting in these cost-effective programs is leading us to depend on more expensive programs which is driving our Medicaid costs.

MS. SCHORR: That's exactly it.

CHAIRWOMAN WEINSTEIN: Thank you.

To the Senate.

SENATOR BROUK: Absolutely. Next we have Senator Mannion.

SENATOR MANNION: Thank you, Chair.

Michael, I apologize, because I had to duck in and out. I know we've had conversations in the past about the great challenges that we face in delivering services for individuals with disabilities and how, you know, workforce is certainly a

piece of that.

I know that you've proposed a task force or a blue-ribbon commission to really look at this holistically so that we can have a pathway forward that is manageable, practical, meaningful, and has -- you know, makes significant changes where they're needed.

Can you just provide a little -- I missed it, but can you tell me a little bit about what you think the commission would look like as far as its composition and how it would -- the results it would produce and potential legislation that might be required?

MR. SEEREITER: I think it can be assembled in any number of ways. You can use many of the commission models of past years or experiences to look at that.

I think you really want to look at the fact that you have a system that was designed to operate with an entire cadre of people who no longer are within our workforce, and on the horizon we don't expect to see those individuals coming back to our workforce. So

that means we need to fundamentally think about how we do things differently -- how do we support people to live more independently with fewer direct supports, but using, for example, technology to support people to live more independently.

But one of the major factors -- and I mentioned this before -- is we need to have a very significant conversation about what constitutes quality, and we need to shift our system from one that has activities like checking the temperature of the refrigerator once a day to things that are actually meaningful to the people receiving services and their families. And use those as an opportunity to shift our system so that we're using that precious direct support professional time a lot more efficiently than we are today. You push in technology in a very significant way, and quite frankly you need to experiment with some different ways in which to serve people and support people.

I think of this when I think of the concept of prototypes, taking things that

have promising practice in a pilot and then replicating that in four, five, six locations across the state with different populations of people, providing services, receiving services, urban, rural, upstate, downstate. And you start to learn what works and what does not work well so that you can replicate the things that work well and you can stop spending money and time and resources on the things that don't work well.

We need to comprehensively rethink what services and supports are going to look like for people like my brother for the next 50 years. We are well overdue, quite frankly, in our opportunity to look at that.

SENATOR MANNION: Thank you.

MR. SEEREITER: Sure.

CHAIRWOMAN WEINSTEIN: We go to Assemblywoman Chandler-Waterman.

ASSEMBLYWOMAN CHANDLER-WATERMAN: Thank you so much, Chair.

Thank you to all the panelists. Thank you for the important work that you do. That's very significant to my family and my

community.

We are happy with the passage of Daniel's task force. We can't wait to take what we learn and start implementing it, and also look for the passage of Daniel's Law. So thank you, Harvey, working closely with our Assembly District 58, you know, Mental Health Task Force members.

I want to ask you a question based on your knowledge of mental health emergencies and response teams. Where does Daniel's Law fit into the crisis -- the continuous services continuum? And what else is needed to make it effective? What are the needed steps to get Daniel's Law teams with peers on the ground to respond to mental health emergencies?

MR. ROSENTHAL: Let me see if I got it right.

So when the -- instead of being arrested or worse, killed or, you know, those kind of interactions, the mental health worker or the EMS worker -- in some cases you might be having a medical condition; we'd

make sure that that was addressed. But in terms of a mental health condition, there's a number of alternatives to admission or even the emergency room.

We have now crisis stabilization centers, crisis respite programs. So we have places for people to go that are not as traumatizing and that are alternatives to mainly arrest and incarceration. You know, but we have a continuum in mental health that I think is growing and needs to be more -- and it needs to be sensitized to people, you know, who have justice-involvement. We are developing peer programs in that space.

ASSEMBLYWOMAN CHANDLER-WATERMAN: Thank you. And what other community-based services are needed that are not listed in the Executive Budget?

MR. ROSENTHAL: That are not in this budget?

ASSEMBLYWOMAN CHANDLER-WATERMAN: Yes. What other community-based services?

MR. ROSENTHAL: Well, everything I want. The Peer Bridger program. More INSET

programs. My computer's off here.

More Housing First. OMH has housing, but really it doesn't seem like it's real Housing First. You have to invest in that so that people who really are using and who are having symptoms still need a place to go that's not an emergency room or jail or prison. That's that model. It's old, long-time; they're not funding in enough.

ASSEMBLYWOMAN CHANDLER-WATERMAN: Thank you so much.

MR. ROSENTHAL: You're welcome.

CHAIRWOMAN WEINSTEIN: Now we go to Assemblyman Maher.

ASSEMBLYMAN MAHER: Thank you.

And a lot of you addressed a lot of the questions I was going to ask, so I just want to start by saying thank you for all of the work that you're doing, boots on the ground. We appreciate you.

A lot of folks that we work with that call our office that need help, whether it's a teenager and her mother can't work within the issues that they're having -- there's

violence, there's mental health issues. You'll call on the police, they'll go to the hospital, they'll pass seven to 10 days, then they'll go back home and they'll go to the hospital and go back home and go to the hospital.

It seems like there's a lot of issues for both mental health and for addiction where we're in need of more inpatient services, more beds. In your opinion, because you've been doing this work for so long, why have we not been able to meet those needs? Why does this continue to be a crisis? Why -- what is it that's holding us back?

MR. ROSENTHAL: You know, there's a lot of thinking that we need more beds. I'm not sure that a bed is always the answer. It's pretty traumatizing. And people don't recover in a hospital, and they often leave for the bad discharge and no place to go. Now we're forcibly admitting people because they have problems with food, shelter and clothing. That's not what a hospital's

supposed to do. So we have to really build in this continuum of alternatives to hospitals.

While I've got the floor, the Governor wants to close five state prisons. We have 24 state hospitals, more than California, Maryland, Texas, and one other state I can't remember combined. It's time to look at that again. You know, you have time until next year. But we started the recovery system by closing five state hospitals and replacing them with this array of alternatives.

ASSEMBLYMAN MAHER: I agree, and that was actually my point, that the hospital is not the place. Right? But there's no other locations, not enough beds in terms of those facilities for that care that they need, for the surroundings they need. And that's where I'd like to get some ideas on why we're not hitting that mark.

MS. FAGEN: So I've been working in outpatient mental health treatment for about 20 years, and currently still do. And we see about 300 people a week, so we're small

compared to these big guys. But it seems to me that this is all related.

So if there's a waiting list, so if a teen is in crisis, if we catch it at the beginning or even before it's a crisis, then we don't move to possibly needing to go to a Four Winds or some kind of inpatient facility because we got an early intervention. If you think of it almost as an early intervention approach.

And the teens and the kids, to somebody's question earlier, are actually pretty keen on getting services. It's the parents who are reluctant and resistant and/or the access to care because they can't find a Medicaid provider, which becomes an issue in our community. Or their commercial insurance isn't covering certain licenses, et cetera.

So I really think it's an early intervention problem. And if we don't have people at the outpatient level that can actually see people when they're at the outpatient level, then they move to the

hospitals.

ASSEMBLYMAN MAHER: Would love to connect with you all offline.

MS. SCHORR: We also -- we didn't really touch on addiction there, but I think there's also a way to address that outpatient, using medications --

CHAIRWOMAN WEINSTEIN: Thank you --

MS. SCHORR: -- things that are fully funded.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to our final questioner, Assemblywoman Giglio.

ASSEMBLYWOMAN GIGLIO: Okay. So again, thank you all for being here.

And Michael, my question is for you, to continue our conversation from this morning about people leaving a group home and going into a hospital and then maybe not being able to come back to the group home because they might be on a feeding tube or they may be needing some further help than what they can get in the group home because of the short staffing.

So can you just finish up on our conversation and tell us how to fix that.

MR. SEEREITER: Sure, absolutely.

Quite frankly, I think this needs to get considered as part of a reenvisioning process for the Office for People with Developmental Disabilities. It needs to be a much more nimble system to be able to meet the needs of individuals when those needs show up.

The way that that works right now is that when an individual who needs an inpatient level of support goes into a hospital setting, they stay, on average, two-and-a-half-times longer than the rest of the Medicaid population, which is a long time.

Many people get stuck for months and sometimes years. We have some of these crisis diversion and crisis respite types of approaches that do seem to work quite well. We need to model them out further and test them with more rigor in other localities and other locations.

But the problem is that when a provider is looking to support someone to come back to where they live, their home, there's not a reimbursement to be able to -- the reimbursement isn't nimble enough to meet the needs, the increased needs for that period of time. You're going to have to wait at least two years until the next rebasing period to be able to recognize those costs in a cost report to then get reimbursed for it.

That's not how this works when you're living on a shoestring. You just can't do that. So you end up with lots of situations where people are getting stuck in hospitals, otherwise going to a nursing home, otherwise ending up in a homeless shelter and lots of settings that are completely against what the Olmstead Supreme Court decision talks about as the least restrictive setting to support people.

ASSEMBLYWOMAN GIGLIO: Thank you.

And I yield my time for anything else that you would like to add to your testimony, or any of you --

MR. ROSENTHAL: Yes. To answer your question, sometimes it's about the money. We're here for more money, but it's not always more money. It's spending the money we have better.

It's $3,000 a day in a local hospital. It could be three, four, 500,000 a year in a state hospital. Think about the array of services. You know, we're getting hospital crazy because we want to get people off the street because people are afraid or they think it's going to solve the problem, and we're wasting money if we're going to go in that route.

ASSEMBLYWOMAN GIGLIO: And you see more and more hospital beds lined up in the hallways of emergency rooms because the capacity just is not there.

MR. ROSENTHAL: We need alternatives.

MS. SCHORR: Yeah, I also would add to that, and it's true on the addiction side too, that it all comes back to workforce. You could keep adding more and more facilities, but if we don't have the staff to

treat people, regardless of which system you're in, it's a pointless exercise.

ASSEMBLYWOMAN GIGLIO: So the training to recruit people into these fields is a dire need.

MS. SCHORR: It's really where you have to start.

ASSEMBLYWOMAN GIGLIO: Scholarships. Thank you.

SENATOR BROUK: Wonderful. That's the end of our questions. Thank you so much to our panel.

MR. SEEREITER: Thank you.

SENATOR BROUK: Last but certainly not least, we have Panel E. We've got The Arc New York; the Association for Community Living; Times Square Alliance; and Coalition for Self-Direction Families.

(Off the record.)

SENATOR BROUK: Wonderful. We will start with Erik Geizer, CEO of The Arc New York.

MR. GEIZER: Okay, great, thank you. Good afternoon. I'm Erik Geizer, CEO

of The Arc New York, the largest provider of services and supports for people with intellectual and developmental disabilities in New York State -- and probably the country.

You've been hearing all day that our system is in crisis. Quite frankly, you've been hearing it year after year after year. And we do think you've listened, and we appreciate that. You've made recent investments into our field. But it's dangerously easy to think that years of disinvestment have been addressed and the crisis has been resolved. Today I'm here to show you why it's not.

Fifteen years ago the average DSP made nearly twice the minimum wage. Today, the average DSP starts at $16.48 an hour, only 10 percent above minimum wage. In our written testimony we graphed the decline over time, and the result was stunning even to us.

I want to just hold this up (showing graph). The trajectory -- this is the trajectory of the value New York places on

DSPs.

CHAIRWOMAN WEINSTEIN: I'm sorry to interrupt, but we don't allow signs or placards or that.

MR. GEIZER: Oh. Okay.

CHAIRWOMAN WEINSTEIN: Thank you. But you're welcome to share it with the committee afterwards.

MR. GEIZER: Okay.

The trajectory has gone down for our DSPs. The trajectory of our DSP compensation over the last 15 years has decreased significantly. And the trajectory of their quality of life has gone down. It has plummeted. Now, you've made investments, and they are appreciated. But this is where we are after those investments.

A recent Miami University of Ohio study reported that half of New York's DSPs are experiencing food insecurity. Half are experiencing housing insecurity. This should be shocking. These are trained professionals with a high level of responsibility for the well-being of vulnerable New Yorkers, and

providers have been forced to set up food pantries for staff.

These are people working tirelessly to ensure the needs of people they support are met, and they are skipping meals because the work doesn't even meet their needs of their own family.

The work of a DSP is very fulfilling. It's important. It's not easy work. In the daily activity of a DSP you might be cleaning wounds, you might be helping with toileting, you're managing complex medication, you're operating feeding tubes and colostomy bags, you're deescalating explosive behavior. Would you do all that for $16 an hour? My teenager can make that at a cash register.

According to the Miami University of Ohio survey, 85 percent of DSPs are satisfied in their work -- 85 percent -- yet one in three leave the field every year, and there are 20,000 vacancies across the state. Because, quite frankly, fulfillment doesn't feed your family. Until we change that trajectory, we can't fix our system.

We're asking for a 3.2 percent COLA and a DSWE of $4,000 per employee. We need your support. Thank you.

SENATOR BROUK: Thank you.

Next we have Sebrina Barrett, executive director of the Association for Community Living.

MS. BARRETT: Thank you.

I am Sebrina Barrett, executive director of the Association for Community Living. Our members provide housing in communities across New York State for more than 42,000 people with severe mental illness. Our staff help them achieve recovery and independence, but today our staff are struggling.

More than one in five positions are vacant. Those who show up to work have to do more. Many don't make a living wage; they have to work two or three jobs to support their families. They can't afford childcare.

Our ability to recruit and retain workers is becoming harder and harder. Our members report a reduced applicant pool,

significant interview no-shows, and a high staff turnover. We need a full 3.2 percent COLA. Anything less is a cut because we have to keep pace with inflation or else we will again go backward and have a funding gap.

Our members know well what that looks like. After years of zero COLAs, they cut, they scrimped, and they learned to do more with less. There are no more corners that can be cut, there are no more pennies to be pinched.

Housing providers are grateful for the investments over the past two years, but those have only allowed us to take a breath. They are not enough to modernize our models. Our models are outdated and struggling to serve today's residents. They were created as many as 40 years ago, and since then everything has changed but the funding.

And let me say this. It is a COLA. Wages are important. But part of retention is a modernized model. We are asking staff to perform miracles with old models, and we're paying them less to do it. It's no

wonder they're leaving.

Today's residents take 15-plus daily medications, as opposed to yesterday's residents who took one or two. There are no more daytime rehabilitation programs where they can attend, so they rely on housing staff. They have multiple co-occurring conditions like substance use disorder and struggle with severe addictions.

Today's residents are older. They have complex medical conditions and daily living needs that our programs weren't created to provide. They live in programs that are highly regulated, require technology and privacy resources, and security measures that weren't even thought about when our models were created.

Our residents are individuals who are considered the hardest to serve in the community. They come from state and community hospitals, jails and prisons, street homelessness and shelters. They live in models that are 30 to 40 years old. They deserve to live in models that meet today's

needs. Our staff deserve to work in modern models where they have a chance at helping the residents reach success.

We recognize that model enhancements will require an investment. We have a plan that we estimate the cost of these investments would be about $230 million. We know that that has to be phased in over time, but it's also a plan that cannot wait.

We respectfully request a full 3.2 percent COLA as well as additional investments so that we can modernize our outdated programs and begin to meet today's needs.

Thank you.

SENATOR BROUK: Thank you so much.

Next we'll have Tom Harris, president of Times Square Alliance.

MR. HARRIS: Good afternoon, chairs and members of the Senate and Assembly. Thank you very much for your time today.

My name is Tom Harris, president of the Times Square Alliance. I would like to commend the Governor, the Senate and the

Assembly for making robust support for mental health services a continued priority. It is certainly one of the greatest challenges we face on the streets of Midtown Manhattan.

Holding hospitals accountable and opening more beds are great first steps, but more is needed. The Times Square Alliance has been providing service and support to those in need in Times Square since 1992. Our Community First initiative, that has peer navigators and a clubhouse model, has reduced homelessness on our streets from 31 to 10. Those 10 high-need people require a different approach to keep them from dying slowly on the streets or, more probably, committing a crime and ending up in the very criminal justice system we have all been trying to keep them from.

One of our community members, Emma Linda, who's been on the street for six years, lives in an encampment laden with flammable materials. Another homeless man, Mohammad, who has a history of violent behavior and who has threatened members of

the public, has lived on the streets of Times Square for over six years. A woman, Salvation, has been on our streets for five years and has clear signs of psychosis, yet denies that she is homeless and rejects any offer of services. Another woman, Sabria, known to have been living on our streets with mental illness for two years, just had surgery and narrowly avoided having her legs amputated. She was told to stay indoors, but she refused and is back on our streets. A man, Gann, living on our streets for the last two years, is known to fake seizures to attract attention, once in the middle of Seventh Avenue traffic.

There's been a 292 percent increase in 311 calls related to unhoused individuals in Times Square -- not because outreach programs aren't trying, but rather because current policies and measures of success fail to adequately support the most vulnerable.

To make meaningful strides and address the totality of issues we see on our streets, we need to focus on and improve outcomes for

all programs, including increasing the number of teams on our streets and establishing meaningful measures of success; clarifying the definition of what constitutes harm to self as a standard; mandate that hospitals use the totality of a patient's history to make a determination of treatment; mandate that hospitals provide outpatient treatment programs and broaden the definition of providers who are authorized to provide 958 removals for the very small percentage of people that outreach alone does not help.

Thank you very much for your time.

SENATOR BROUK: Next, and finally, we'll have Jim Karpe -- I hope I said that right. Okay, great. Jim Karpe, steering committee member for the Coalition for Self-Direction Families.

MR. KARPE: Thank you so much.

I'm Jim Karpe. I'm the father of two young adults with developmental disabilities. I am here representing the Coalition for Self-Direction Families. There's now 30,000 people, one out of every five in the OPWDD

system, who are now in self-direction. And since we don't have another parent here, I'll go ahead and speak for the 130,000 total who are in the OPWDD system.

And so I'll start with endorsing what you've heard from Erik Geizer, what you've heard from Mike Alvaro and many others. We need a living wage for the DSPs. We absolutely need that.

Another 54 cents from 3.2 is not enough. Another $2.54, by putting the wage restoration and the 3.2, is still not enough -- but it's at least a good start.

I'd like to continue by focusing in on innovation. We've heard from Mike Seereiter about some ideas for -- we need a change in the system, because we don't just need money. We need better ways of spending our money. And those of us in self-direction I believe are in the vanguard. We're out there finding new creative ways to bring additional capacity into the system. We don't have enough DSPs, so families have gone out and found community providers who can do things

that are meaningful for our children.

The community class issue is so emotional for us, because it's not just "you don't get to do that," it's an attack on the things that make life meaningful.

The option -- if you don't go to a community class, the option is not you go off to some other meaningful thing. The option is you're sitting at home on the couch watching television. And that is not a more inclusive environment.

We're boxed in. We have to not replicate other services with community classes, but we have to replace, we have to reduce the need for those.

I'm glad to talk to you more. You've got my written testimony, and I'm glad to answer questions. But we need not just money, we need the freedom of choice to spend the money that we're getting today.

Thank you.

SENATOR BROUK: Thank you all.

We will start our questions with Senator Webb.

SENATOR WEBB: Thank you all for being here.

My question is for Mr. Harris. In your testimony you mention that data shows that when a nurse, social worker or other mental health professional conducts removal, patient outcomes as far as connecting with treatment are significantly better than removals conducted by law enforcement.

And so my question is, what can we do as a state to make this norm statewide with regards to mental health professionals being a part of first line of response for persons that are in crisis?

And then my follow-up question is the core function of our mental health system is to help each person who's suffering heal, and to maximize their potential. Would you agree that the best way to do this is to expand access to mental health professionals, including peers?

MR. HARRIS: Great questions.

So first, how can we flip the numbers? So we got this data from the City of New

York. If there's a 941 removal basically done by a police officer, 75 percent of the time they end up back on the street. If it's a 958 removal done by a mental health professional, 75 percent of the time they get the service and support that they need.

So the way to do that is to just increase more people who are authorized to perform those removals on the street.

And then your second question? I apologize. Could you just repeat it quick?

SENATOR WEBB: Yes, sure.

We know that the core function of our mental health system is to help each person in their healing, especially as they're dealing with mental health challenges. So would you agree that the best way to do this is to expand mental health professionals, including peers?

MR. HARRIS: So our Community First program has peer navigators that go out on the streets of Times Square and have been very, very successful -- 31 down to 10. So that is one tool in the toolbox, if you will.

And we also use the clubhouse model. We work with Fountain House. We have a recharge station. And it's a place for gathering, it's a place that's an alibi. They could charge their phone, get coffee. It's all part of a comprehensive system that we have in place.

But there are gaps. And I think some of the items in my testimony would close some of those gaps.

SENATOR WEBB: Thank you.

And with the time that I have left, my last question is as we've been hearing today, you know, we have to continue making investments as pertains to mental health services. We're way behind. And so knowing that this is a fast-growing population in our jails and prisons, are you concerned that relying upon law enforcement as the first line of response for mental health emergencies will exacerbate this phenomenon?

MR. HARRIS: I wouldn't do that. I wouldn't think that having law enforcement as a first order of response makes any sense.

SENATOR WEBB: Thank you.

SENATOR BROUK: Thank you.

I'm going to now be Assemblymember Weinstein too -- oh, you want to go? Oh, she's not ready to go yet. Okay, go ahead.

CHAIRWOMAN WEINSTEIN: But I'm going to have to run to our conference in a few moments.

Assemblywoman Seawright.

ASSEMBLYWOMAN SEAWRIGHT: Thank you, Chair Weinstein.

And thank you to our panel for your testimony today.

I have two questions. I'd like to direct the first one to Jim Karpe.

You brought up concerns with Medicaid, including the agency's consideration of moving to a managed care model for certain services. At the same time you mentioned that non-certified services are under attack. How do you see such services faring under a managed care model?

MR. KARPE: So hopefully we don't have to find out. Managed care is in so many ways

the opposite of self-direction. The decision's being made not by the person in cooperation with their family, their circle of support, it's being made by somebody at a managed care organization.

So the three models that we've seen are, in other states, self-direction just gets completely carved out. Another model we've seen is the managed care organization says, Sure, we'll take our 6 percent, thank you very much, increases our bottom line, and you get the other 94 percent, you get to use it.

And the model that I'm not sure is actually in place anywhere is where the managed care organization tries to interfere with the individual choice. I don't know whether they've even tried that one.

ASSEMBLYWOMAN SEAWRIGHT: Thank you.

And my next question is for Mr. Geizer. Your testimony and leadership of Arc is commendable, and I thank you.

According to your report, 15 years ago the average DSP wage was nearly twice the

minimum wage. What do you see as the cause for this rapid devaluation of DSP workers? If you could comment on that.

MR. GEIZER: Sure. Let me just open the mic.

So you're correct, 15 years ago the average DSP wage was twice the minimum wage. Over the 15 years since that time, the trajectory, as I mentioned in the testimony, has gone down precipitously. It's essentially due to a lack of investment in our system.

For 10 years there were absolutely no COLAs for our system -- zeroes. Now, while over the past three years we've received some investment, even this year the 1.5 percent that's being proposed by the Governor doesn't even keep up with inflation. So unless we find the additional 1.7 percent to make up the difference, we're going to fall behind yet again, and that trajectory will continue to drop.

ASSEMBLYWOMAN SEAWRIGHT: Thank you.

SENATOR BROUK: Okay, back to the

Senate. We'll have Senator Rolison.

SENATOR ROLISON: Thank you, Madam Chair.

Mr. Geizer, I recently had the honor to go to The Arc in New Windsor, and I just have to say that experience and how they interacted, both at a staff level and also the individuals that participate in those programs, was really, really --

MR. GEIZER: Thank you.

SENATOR ROLISON: -- not only heartfelt, it just -- it made the week to see what was happening there.

And then listening to the testimony throughout the day, and the DSPs and all that -- and I understand that completely. I think obviously everybody does. But I just -- there have been a couple of comments that were made, in the last panel too -- we've heard it here, I think Sebrina talked about, you know, the same old models.

So how -- if you're going to change a model, and you're in a system with state support and state guidelines, how does that

work? Or does it work?

MS. BARRETT: So yeah, we had a workgroup and we have a plan that essentially would take the best of what our model has, but we would add staff -- because the staffing model was created, as I said, in the '80s when there were other resources. Daytime programs, the residents would leave and be gone for the day. Today they're there all day long. And so the same number of staff that worked then doesn't work now.

Also we have residents with more challenging needs. And so we need different-credentialed staff. The staffing that is in mental health housing programs right now are paraprofessionals. We don't have nurses. We don't have -- you know, we have very few licensed professionals. These are folks with high school diplomas who come in and get training. And they are making just above minimum wage.

Housing is the same as these other programs that we've been talking about. In the 1980s, our staff made three times the

minimum wage. Today they make just a buck or two over. They can make more money flipping a hamburger.

So we're really asking staff to deal with a much more challenging population with less -- with a staff that is less educated and is compensated in a lower fashion.

So those are the enhancements we would make: More staff, different-credentialed staff. We would also add staffing for maintenance and housekeeping. That's all extra. So all the money that we spend on that is money that is taken away from service provision.

SENATOR ROLISON: And thank you for that.

And Mr. Harris, I just concluded seven years as mayor of the City of Poughkeepsie, and have looked at your model in Times Square. And kudos to you for that.

MR. HARRIS: Thanks.

And I think just to follow up on your other question, the way we changed that was we had an outcome-based measure of success,

not process-based. So we looked to reduce the number of people who slept on the streets and increase the number of people we provided services for instead of just counting and asking people if they want services.

SENATOR ROLISON: Thank you.

Thank you all.

MR. HARRIS: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblywoman Giglio.

ASSEMBLYWOMAN GIGLIO: Yes, thank you all for being here.

And my question is for Erik, from The Arc, because I was there last -- the winter of 2021, and it was explained to me that the programs, a lot of the programs that you provided, such as bowling or going to see a movie and things like that -- quality-of-life issues for the people that are living in the homes -- that those programs are no longer happening. They were decreased by 38 percent in 2021.

So I'd like for you to talk to me about -- and to us -- about the quality of

life of the people within the homes, by not having adequate staffing with DSPs.

MR. GEIZER: Sure.

So my testimony today focused primarily on the wages and compensation for our DSPs. But I want to make the connection to quality of care, because it's the people we support and serve, they're the ones that are being impacted.

When we don't have enough staff in our homes, we can't take them on recreational events. We can't take them out into the community. Sometimes we have to close programs. That causes people to move to other locations, maybe farther away from family and loved ones.

Staff that can't afford to work in our field. You know, we're providing the most intimate of care to the people we support. Imagine someone you don't know coming in every other day and providing those supports and services.

So I know we've talked a lot about wages today, and that's really where it

starts. It starts and ends with staff. Because without a decent wage, without a living wage, it impacts the lives of the people we support in an adverse way. So that's really what it's all about.

ASSEMBLYWOMAN GIGLIO: Okay. And then for Mr. Harris -- hi.

MR. HARRIS: Hi.

ASSEMBLYWOMAN GIGLIO: So when it comes to homelessness and it comes to homelessness that is -- for people that maybe have some mental health issues -- and I know, being a local police commissioner, that the police were the first line of defense. Someone's trying to break into my house or someone's outside my house screaming, and they get picked up, they get brought to CPEP. And then they get returned back to the community that they were in, and they repeat it.

So you're saying law enforcement shouldn't be the first line there, is what I think I heard you say. So what should be the first line in that situation where someone is

screaming outside of somebody's home or banging on the windows?

MR. HARRIS: Well, I suppose it all depends on the scenario.

I think there's a place for law enforcement. Maybe they shouldn't be the first responder unless it's a life-or-death or an emergent situation like that.

So something that you described, someone banging on a door for help, I think definitely the police need to be involved. But there could also be a co-response with other service providers.

ASSEMBLYWOMAN GIGLIO: So when it comes to involuntary admission, we have community ambassadors in Suffolk County that witness -- I'm sorry, I'll catch up with you, because it's --

MR. HARRIS: I'd like that.

ASSEMBLYWOMAN GIGLIO: -- a topic I'm very interested in.

SENATOR BROUK: Next on the Senate side we will have Senator Mannion.

SENATOR MANNION: Thank you, Chair.

A few words I heard today were, recently, innovation, freedom, flexibility, opportunity, choice. When we don't have a workforce, we don't have any of those things, and we don't have quality.

My question is on self-direction, for Jim. There have been recently changes to regulations or qualifications for individuals with self-direction. Can you talk about what those are and what population we're talking about that is under those new rules?

MR. KARPE: So I think what you're referring to are the shadow policies. In November of 2022, OPWDD gave a presentation to the fiscal intermediaries, providing them with 10 red flags that they had a responsibility to look for. And these include a class going for too long, a class advertising itself as being open to the public -- because of course if you say you're open to the public, that's something to be suspicious about.

You heard the commissioner talk about how we must obey the contract that we have

with the federal agency. There's a far-off land on the other side of the Hudson -- New Jersey -- where they apparently have a different federal agency, because they allow classes that are aimed purely for people with I/DD. Their equivalent to OPWDD actually pre-approves a community provider to provide a class.

So the idea that New York is somehow constrained by federal oversight is simply not as true as New York would like to have you believe.

The feds say New York has the right to put in further restrictions if they want, and New York has. And that is having a negative impact on people who are everywhere from very light needs, such as my daughter, to people with very heavy needs, like my colleague Jackie's son, who's nonverbal, six-foot-three, 220 pounds, and won't be taken by most dayhab programs. So she has created something which is a place, a community class where he can go, but now she's under attack, JCCs are under attack.

It's a ridiculous thing. It's an innovation that should be embraced. It's that start of a new thing. And instead, we seem here in New York to be saying, Let's put a stop to that, let's only do what we've done before.

If we keep doing what we've done before, we're not going to make progress.

SENATOR MANNION: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman Maher.

ASSEMBLYMAN MAHER: Thank you.

So I don't think I've met a colleague on either side of the aisle, in the Senate or the Assembly, that doesn't -- that I have talked to that doesn't agree about the 3.2 percent and more. So I'm hoping from now to the budget, that when it's finalized, you guys get that start that you want. I'm, you know, hopeful for that, we'll be pushing for that.

When it comes to innovation, I'm very curious about some of those programs. I know you submitted written testimony. Can you speak to anything that is outside the box in

terms of addressing the need for housing?

MR. KARPE: So with regard to housing, there's the housing subsidy, which is -- it's wonderful that they have increased it, that after a decade of neglect we are now at the current rate. That's fantastic.

It can still be challenging, depending upon the environment. It's adequate in rural areas, it's adequate in some boroughs but not others.

Where we would like to see more innovation is in the ability to support people once they're in that housing. There's a model that's been in -- it's sad to say, New York is 20 years behind Kansas. There's a model that's been in place in Kansas for two decades where people can, using remote technology, be supported in their home by essentially a coach on demand. Not a hotline, but a cold line.

ASSEMBLYMAN MAHER: So I love the fact that we can learn from our -- some of our neighboring states and some not-so-neighboring.

I know there are a lot of hidden costs to individuals and families that are receiving services and that are provided resources. For example, we have a local family that insurance didn't cover a car seat for a larger child that has special needs, and these expenses can be thousands of dollars.

Do you see that there is a shortage of some nonprofit organizations, or maybe there's more synergy that needs to exist in terms of some of those individual expenses? And do you see that as as much of a need as I'm seeing it in my local community?

MR. KARPE: Absolutely. There is a process of getting technical support, support for durable equipment, but it's a very onerous process. Even when it's as clear-cut as your wheelchair has broken and you need a new wheelchair. It's not as fluid as it should be. Absolutely.

ASSEMBLYMAN MAHER: Okay. Thank you all.

SENATOR BROUK: Okay, next we have

Senator Canzoneri-Fitzpatrick.

SENATOR CANZONERI-FITZPATRICK: Thank you, Madam Chair.

Thank you, everybody, for being here.

Mr. Karpe, we had a chance to meet yesterday and I was very happy to learn more about self-direction, and I support what you're trying to do for your family. And I know Jackie as well, and what she's trying to do. So thank you for being here today to testify.

Mr. Harris, I had a question about some of the statistics in your report. Community First navigators have interacted 2,273 times with 881 individuals. So quick math, it seems like we're interacting with the same people two and three times.

And 17 people voluntarily accepted mental health services. So my question to you is, what happened in those 17 specific situations that we need to try to do better with the other 881 people?

And then my follow-up question is about the Supportive Intervention Act,

because my understanding is that involuntary admission is not something that we push for because it doesn't typically work. So I'd like to have you explain why you think that that's going to fix our gaps and flaws.

MR. HARRIS: So first, with -- the Community First model is built on trust. So we go out there, our peer navigators interact with the same people. They meet them where they are, find out what resources and support that are needed, and then we move them to the next step.

So it really is trust-based, building that trust. We work with Breaking Ground, we work with Fountain House, we work with the Center for Justice Innovation so we can sort of provide a robust array of services. And we were lucky that it clicked with those 17 people and they accepted service.

As far as the involuntary removal, it's a tool in the toolbox for a small -- small minority of people who are out on the streets who really are dying slowly. I mean, I have -- I won't share the pictures, but I

could share them afterwards. If you just look at the people who are suffering on our streets and dying slowly or, worse yet, committing crimes and ending up in the criminal justice system, we need to find another option.

And if that option is taking them briefly to a hospital so that we can get a reset and get them back functioning -- we saw two instances when we had involuntary removals last year. It was Code Blue, so they picked up anyone -- it was under 32 degrees. They picked up five people in Times Square. Three of them stayed in, got service and support and never went back to the street.

We did a program with the Mayor's Office of Mental Health where, two weeks in Times Square, intensive, eight people were brought to the hospital with a clinical psychiatrist. They did not come back out to the street.

SENATOR CANZONERI-FITZPATRICK: Thank you.

MR. HARRIS: So it's a balance.

SENATOR BROUK: Next we have Assemblymember Kelles.

ASSEMBLYWOMAN KELLES: I just want to, so it's on the record, share a summary of what I've been hearing today from everyone, just so it's clear. In my mind, one way or another, we're still paying.

I loved that you said at the bottom, it's about the direct service provider -- it's about the providers, making sure that they get paid. Right now, because they're not paid, we have a shortage of 25 percent in some categories of what we need across the board. Right? On top of it, they don't get paid enough, so they're on social services. So we pay there.

We also pay -- because there's not enough, we end up with more people who end up homeless. Because they're homeless, we know that they're more likely to be engaged with the criminal justice system. Again, we pay again.

We have people who have mental health

issues that we're not treating. Many times they end up treating with substance -- you know, ending up with a substance use disorder because they're self-medicating. Again, we pay for that. They end up in the carceral system, again, we pay for that. We have direct service providers that they're -- just to continue to keep working, end up in cases where they have substance use disorders because they don't have time to treat themselves. They end up losing their job, they end up homeless -- spiral, spiral, spiral.

I could just keep going. This is -- I just want to note we still are paying. So why don't we just start paying where we could, which is paying the service providers to prevent all of this stuff in the first place? So I just want to say this is just the most efficient use of our funding. So that's just out of respect to all of you, just to make that note.

I did want to also note that when we're talking about COLA, again, again,

again, it is not a wage increase. It is just to keep a wage cut. That's really important. This Governor, though, she has invested in COLA for the last couple of years. I want to honor her for that. And it's still not enough. We need it to meet inflation every single year, and it has been less than inflation for many of those years.

So I know that isn't a question, and I am sorry for that, but I just wanted you all to know that I hear you. I did just want one last, in the 48 seconds, because I can't ask everyone questions. I met with a group of parents, very, very frustrated with the self-directed program. One of the things they said is that there are nuanced restrictions that seem totally arbitrary that prevent, you know, them using the system.

Can you talk a little bit about those arbitrary restrictions, share a couple of ideas?

MR. KARPE: Yes. So for example, one fiscal intermediary did some freelance policymaking and said anything that lasts

longer than two hours will not be approved.

Other fiscal intermediaries have been forced by fear -- and they're not to blame, but have been forced by fear to sit outside a class and look at the people going in and judge how many of those people are disabled.

SENATOR BROUK: Thank you.

ASSEMBLYWOMAN KELLES: Just a couple of examples. Thank you very much.

SENATOR BROUK: Next we will have --

(Time clock continuing to chime.)

SENATOR BROUK: Okay.

(Laughter.)

SENATOR BROUK: Next we'll have Senator Weber.

SENATOR WEBER: Thank you, Madam Chairwoman.

And I want to thank the panel for being here today and really providing great testimony and real-life and real-world experiences as to what's going on.

You know, we in Rockland County, the legislators, recently met with our DSP providers, and we all saw the fear in their

eyes. You know, whether or not they're going to be able to keep the doors open long-term.

We've heard the -- we've heard the stories of employees sleeping in their cars, not having enough food, not having enough money to pay their rent and the utility bills because they're not making a wage that is anywhere near matching the cost of living where we are downstate.

So I just want to reinforce -- and I know my colleagues feel the same way, you know. The wage enhancement, totally in favor of it. The COLA increase, 3.2, it probably should be 6.4, higher than that. I think we all realize that. And I believe if we all had a magic wand, we would make that happen right now. And that's the commitment I know you have from this legislative branch.

Jim, I just want to pick up on a few things, because I meet with self-direction family advocates all the time. And the community class -- you know, the frustration with the community classes is something that I know is of major concern with them.

And maybe you could just speak to that a little bit more. And also maybe -- also speak to what administrative changes would you like to see made at OPWDD? If you had a priority list, what things can be done, you know, administratively that you think would free up the system and be helpful in so many ways?

MR. KARPE: So thank you for that opening.

One thing that the community of self-direction families believes would be very useful would be to have a seat at the table. Not someone for us to talk to, but somebody to talk for us. When the commissioner sits with her deputies, there is not anybody who represents self-direction. To find somebody who's devoted to self-direction, you have to go not one level, not two levels, but three levels below the commissioner. So you have people from audit and you have people from budget, and you don't have somebody who can say, No, it's not true that self-direction is more expensive

per person. And no, it's not true that self-direction is less equitable.

Self-direction is actually, at this point, based on OPWDD's statistics, is more equitable than certified residences. We still have a lot of room to go. If they could prepay for -- right now it requires reimbursement, and that creates a financial barrier to entry. I am, at any point in time, waiting for $5,000 in reimbursement. I'm blessed to be able to do that. There's a lot of families out there who don't. It wouldn't take that much money to eliminate that.

SENATOR BROUK: Thank you.

SENATOR WEBER: Thank you.

SENATOR BROUK: Next we'll go to Assemblymember Burdick.

ASSEMBLYMAN BURDICK: Thank you.

And sorry that I'm a little late to hearing this panel.

Questions for Mr. Karpe, but before that I would say that I am joining the chorus of everyone who wants to see the 3.2 percent

and the $4,000 wage enhancement. I think probably all of us have been to rallies and so forth for that.

But I want to go back to the conversation that a number of us had with you about community classes. And I guess it must be the New Jersey Division of Developmental Disabilities that has said CMS allows for this. Do you happen to know whether they got a waiver for that? Did they get anything that is in writing from CMS that we then can discuss with OPWDD? That's one question that I have for you.

A second one -- and I may have some more that I'll do in writing. And if you've already been asked this question, just forget it. You brought up concerns about managed care. And I'd like to know a little bit more about our opposition to that.

MR. KARPE: Sure.

So CMS -- I fear that what's going on is that New York still has a relationship with the CMS in the mind of 20 years ago.

ASSEMBLYMAN BURDICK: No, I get that,

Jim. You and I talked about that a little bit.

MR. KARPE: But CMS has --

ASSEMBLYMAN BURDICK: But do you know whether New Jersey has gotten anything in writing from CMS that says, Yes, you can pre-approve classes, as an example?

MR. KARPE: Well, they --

ASSEMBLYMAN BURDICK: Anything that we could use that --

MR. KARPE: Well, they have it as their -- as their policy. So I assume it's been reviewed in some way.

ASSEMBLYMAN BURDICK: It's their policy in writing, in --

MR. KARPE: Yes, it's their policy in writing.

ASSEMBLYMAN BURDICK: CMS has to approve that, presumably, right?

MR. KARPE: Yeah. Yeah. So it's based on their waiver. I haven't gone through the investigation of their waiver, but I'm --

ASSEMBLYMAN BURDICK: Okay. It might

be helpful if you can get us a copy of the New Jersey policy.

MR. KARPE: Yup.

ASSEMBLYMAN BURDICK: That could be helpful for us in talking with OPWDD.

MR. KARPE: Sure.

ASSEMBLYMAN BURDICK: Because, look, there have been issues that OPWDD in past years has had, you know, that they had to correct with CMS, as you may know.

MR. KARPE: Yeah.

ASSEMBLYMAN BURDICK: And so I think that we have to get over that resistance.

MR. KARPE: Yeah, it's page 121 of their --

ASSEMBLYMAN BURDICK: And your -- your opposition to managed care.

MR. KARPE: Yeah, regarding managed care, managed care makes beautiful promises, right? It's -- it's an absolutely lovely system on paper. The problem is it doesn't deliver on those promises. It does not actually reduce costs, it does not improve quality.

The one thing that it's been shown to do is to reduce the rate of hospitalization, the rate of emergency room use. But we can do that just by providing group homes and people not in group homes with access to the thing -- to telehealth.

ASSEMBLYMAN BURDICK: So what doesn't it do?

MR. KARPE: Well, what it does do is it increases --

ASSEMBLYMAN BURDICK: Does not do.

MR. KARPE: It doesn't really do anything except for hold 6 to 12 percent of the budget out of the system.

ASSEMBLYMAN BURDICK: Thank you.

SENATOR BROUK: Thank you.

All right, last three minutes. You're almost done, so thank you all so much.

I want to just start with Sebrina. You talked about a $230 million investment about modernizing care. Can you just give another example of what some of that modernization could look like?

MS. BARRETT: Yeah, sure. You and I

have talked a lot about the aging population in OMH housing. Our residents -- it's good news, they're getting older, that means they're living longer. But, you know, we have about 40 percent of our residents who are age 55 or older; a third of them are age 65 and older. And folks with severe mental illness age more quickly. And so they present a lot of really challenging medical needs, mobility issues, dementia, COPD, all those things.

And so we don't have the right kind of staff to help them with those issues. And so what ends up happening is rather than doing something on the preventative side or something that can keep someone out of an emergency room or out of a long-term hospital stay, can help them age in place, they just end up cycling back and forth from the residence.

Also, a lot of our residences aren't equipped for mobility. So enhancements would also just add things that would enable people to move around.

And we also have residents who are unable to -- they need help with toileting and they need help with bathing. That is not something our current staff are even trained or even really supposed to be helping with. So that's a part of the enhancements, along with a lot of the other challenges that we've talked about.

SENATOR BROUK: Thank you. I appreciate that. And I think it is a good thing that we have an aging population, but it also means we need to change what we do.

My last minute and a half I want to go back to Mr. Harris talking about some of the things you've discussed. So in hearing the statistics about 75 percent of folks who were engaged with -- I think you said peers or social workers or mental health providers, got the services they needed.

MR. HARRIS: (Mic off; inaudible.)

SENATOR BROUK: Mental health providers. Okay. That's really -- that's successful.

So I guess my question is -- I know

you talked about some ways to expand involuntary treatment. But my question would be there are so many successful voluntary programs, which obviously is -- should be the goal. Have you looked at additional services? And one example is one we heard about earlier today with INSET, where they had an 83 percent success rate of successfully engaging folks who need this kind of care.

So what work can we do to really make sure that we have a clear understanding of all of the existing voluntary methods of getting people services that they need?

MR. HARRIS: So voluntary options are first, second, third options. I mean, it's only as a last resort, when everything else fails, that it's inhumane to just let those people stay on the street without taking them in, to having someone evaluate them.

SENATOR BROUK: Would you be willing to look at others, though, that perhaps you all aren't as familiar with, and --

MR. HARRIS: Oh, sure. I mean, we've

been looking at -- I mean, our Community First model sort of looked at everything and tried to pull best practices. There are just some people that --

SENATOR BROUK: Thank you.

MR. HARRIS: Yeah.

SENATOR BROUK: All right. All right, we did it! Thank you all so much to Panel E for sticking it out.

And I guess that concludes the Mental Hygiene hearing, with Samra Brouk as Liz Krueger.

(Laughter.)

MULTIPLE PANELISTS: Thank you.

SENATOR BROUK: Thank you.

(Whereupon, at 4:34 p.m., the budget hearing concluded.)