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Testimony of the New York Civil Liberties Union
Before the Joint Legislative Budget Hearing on Mental Hygiene

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The New York Civil Liberties Union (NYCLU) appreciates this opportunity to submit the following testimony for the Joint Legislative Budget Hearing on Mental Hygiene. The NYCLU, the New York State affiliate of the American Civil Liberties Union, is a not-for-profit, nonpartisan organization with eight offices throughout the state and over 85,000 members and supporters.

The NYCLU defends and promotes the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution, and the New York Constitution, including the right of every New Yorker to enjoy life, liberty, due process, and equal protection under law. This includes our work in pursuit of community safety, and our work to advance the rights of New Yorkers with disabilities and New Yorkers who are unhoused. Those rights rest on core civil liberties principles, including the rights of due process, individual autonomy, bodily integrity and dignity.

We submit this testimony to express the NYCLU's concerns about several proposals in the FY 2025 Health and Mental Hygiene (HMH) Article VII bills. First, we express grave concerns regarding Governor Hochul's proposed changes to Article 9 of the N.Y. Mental Hygiene Law, including the policy and legal deficiencies with respect to the definitional changes proposed to § 9.01 and the changes proposed to § 9.60 ("Kendra's Law") that are set forth in HMH Part EE. Second, we address the risks of compromise to our State's recently enacted shield laws for medical professionals who perform reproductive health care and gender affirming cares that is implicated by the State entering into an interstate nursing compact as proposed in HMH Part W. And third, we express our opposition to the Office for People with Developmental Disabilities (OPWDD) managed care extender proposed in HMH Part CC.

We also offer a number of recommendations for the Legislature to consider concerning alternative evidence-based programs and other initiatives that will strengthen the public mental health system's ability to respond to the needs of individuals with serious mental illness. Our recommendations fall into several categories, encompassing oversight and accountability measures, housing, peer services and family support programs, consensual care delivery accomplished by way of enhanced voluntary services packages in lieu of involuntary outpatient commitment orders, expansion of community-based preventative services offered by the Assertive Community Treatment (ACT) and Forensic ACT teams. We urge the Legislature to update the Temporary Disability Insurance (TDI) Program which supports New Yorkers with disabilities who must leave the workforce for temporary periods of time and provide enhanced workforce support and workforce development measures. We also urge the Legislature to consider the additional recommendations set forth in the Mental Health Association in New York State ("MHANY")'s

recently issued 10-point plan that aims to close the gaps in mental health services delivery, including crisis response.

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I. Proposed Changes to Article 9 of the N.Y. Mental Hygiene Law

The proposed amendments to Article 9 of the Mental Hygiene Law raise issues ranging from biased-based, racist policing to the harms associated with police contact with people living with mental illness. As interactions between police officers and vulnerable New Yorkers who are unhoused and living with mental health challenges continue to have featured prominently in our local and national conversation, with recent high profile incidents on the subway having rekindled public attention, we have seen predictable – if ultimately misguided – calls for law enforcement and the courts to do more to remove unhoused people off the streets and out of the subway.

The Governor is right that the status quo response to homelessness and serious mental health issues is untenable. But the change we need is not simply to lock more people away, especially those who pose no immediate threat to themselves or others. That does not make us safer, it distracts us from addressing the roots of our problems, and it threatens New Yorkers' rights and liberties.

Our criticisms of the Governor's plan today rests on the following objections:

- the proposed revisions continue to **direct resources into a failed strategy** of involuntary psychiatric hospitalization and forced treatment, at a time when the State and New York City have continued to reduce or eliminate investment in effective strategies that connect people to long term treatment and care;
- the proposed revisions **allow removals that are not justified** under the U.S. Constitution or New York State Mental Hygiene Law;
- the proposed revisions **reflect and will exacerbate bias** against unhoused people and people with mental illness and will disproportionately burden New Yorkers of color; and
- as with many of these immoral initiatives directed at people who are unhoused and at people with disabilities, there has been from the start **a complete lack of transparency, clear processes, and failure of data collection and reporting**—rather, information is released via press conference and via highly controlled and selective disclosure to chosen media outlets and the data released is incomplete and/or conflicting.

Governor Hochul's budget proposals continue to reflect an approach that plays fast and loose with the legal rights of New Yorkers, while not dedicating the resources necessary to address the mental health crises that affect our communities. From the start of her tenure, Governor Hochul

has been pursuing these same fundamental and unconstitutional alterations to long-standing legal standards.

Both our federal and State courts have crafted the legal standards relating to inpatient commitment and forced treatment to meet the demands of due process protection while striking a fair balance between the rights of the individual and the legitimate concerns of the state. *See, e.g. Boggs v. Health Hosps. Corp.*, 132 A.D.2d 340 (1st Dept. 1987).

Involuntary commitment and forced treatment – either on an inpatient basis or under a Kendra's Law order – is an extraordinary use of state power and the Second Circuit Court of Appeals, the New York Court of Appeals and New York's appellate and trial courts have all held the exercise of state power is subject to clear constitutional limits to prevent abuse – limits which the Governor's proposed expansion is likely to violate.[1] Expanding the standard of "harm to self" and creating a broader dragnet to force people into treatment is a provably failed strategy for connecting people to long-term effective treatment and care. In other words, the Governor's plan would do nothing to further public safety.

Moreover, the new powers the Governor has sought are not needed. Existing law provides a mechanism when system breakdowns result in acts of violence and tragedy for the State to immediately assess what went wrong and to evaluate how such incidents can be prevented going forward. Incident review panels have been authorized by Mental Hygiene Law § 31.37 since 2013 but OMH has **never** implemented those critical incident review panels.[2] Existing law also already establishes when involuntary commitment and treatment are appropriate constrictions of a person's rights. According to the New York City Department of Health and Mental Hygiene, one in every four New York City residents live with a mental health challenge.[3] Both the Governor and New York City Mayor Adams claim to know exactly which 100 New Yorkers are in need of heightened scrutiny and heightened restrictive interventions – to protect them and to safeguard public safety.[4] Why, then, are the Governor, and the Mayor, seeking to impose a lowered standard, that can be used against so many New Yorkers who do not require involuntary commitment and involuntary treatment, a standard that will be exercised by law enforcement who are simply incapable of rendering any informed clinical analysis in effectuating mental hygiene arrests of New Yorkers?

In New York City, police and other city officials already routinely conduct mental hygiene arrests under MHL § 9.41, in aid of transport for assessment and involuntarily commitment. In fact, according to the City's own (incomplete) data, over 7000 New Yorkers were involuntarily transported in 2024 for psychiatric inpatient assessment.[5] According to Mayor Adams, the City has averaged at least 137 involuntary removals per week since May 2023.[6] What exactly happens to these New Yorkers after they are involuntarily committed is not clear and is not made publicly available. What research does make clear is that coercing people into mental health care is generally ineffective and does little to improve people's mental health. Elected officials across New York State and New York City are fully aware of this, yet they routinely default to this proscriptive response rather than taking steps to fix the long-running mental health crisis in our state.

Forcing people into treatment is a failed strategy for connecting people to long-term treatment and care.[7] Unless we adequately invest in the long-term health and well-being of New Yorkers facing mental illness and our chronic lack of housing, the current mental health crisis will continue. The

decades-old practice of sweeping deep-seated problems out of public view may play well for the politicians, but the problems will persist – for vulnerable people in desperate need of government services and for all New Yorkers.

The Governor's repeated attempts to police away homelessness and sweep individuals out of sight is a page from the failed playbook of countless State administrations before hers.[8] With no real plan for housing, services, or supports, the administration is choosing handcuffs and coercion. It is magical thinking to assume that the subways and the streets will not function as housing when the City and state simply offer nothing other than involuntary transport to a psychiatric facility for "observation" under threat of compelled inpatient psychiatric treatment.

The current system fails those subject to this summary assessment and those subject to involuntary commitment. People who are brought in for psychiatric assessment are often discharged without any connection to services, or worse, they are bounced from one under-resourced facility after another before returning to the street. OMH regulation mandates that MHL § 29.15, which mandates discharge planning for people "admitted" to inpatient psychiatric services, specifically does NOT apply to people who are brought in for psychiatric evaluation. *See* 14 NYCRR 790.8(g).[9] With no supportive housing or care manager who can help navigate a complex system to access scarce mental health and housing services, the cycle repeats. The Governor's proposed Article 9 amendments simply make it easier to sweep people out of the public domain, only to widen that spiral.

The Governor is well aware that the real problem is there are not nearly enough mental health care resources available, especially for those who need them the most, especially including people subject to involuntary commitment. Further criminalizing people with mental health issues, who are themselves 11 times more likely to be the victim of crimes[10] does absolutely nothing to improve care or our dire housing shortage.

There is enormous bias reflected in statements accompanying both the Governor's and the Mayor's public discussion of the Governor's continuous efforts to amend MHL §§ 9.01 and 9.60, as well as their statements concerning the various joint city and state initiatives to sweep New Yorkers, who are disproportionately people of color, who are unhoused or experiencing mental illness, out of public sight and into institutional settings and forced treatment. At bottom, the Governor's policies simply presume that people living with mental illness are all dangerous criminals.[11] That presumption is both morally and factually wrong. At a time when communities are demanding resources to address mental health, homelessness, and economic crises, the Governor's plan focuses on criminalization and forced treatment.

We urge the Legislature to continue to keep intense focus on the investment of resources and connection of people with consensual care – proven approaches to help people in the long term. And we urge the Legislature to push back against what appears to be both the Governor's and Mayor Adams' intent to recraft a mental health system to permit easier removal and forced treatment of people without addressing systematic dysfunctionality – particularly with respect to the well-documented lack of supportive housing and culturally appropriate supports and services. Short-term forced treatment and criminalization are demonstrably ineffective approaches to meaningful change. New Yorkers need more direct access to economic, health and care resources – not more police.

A. Proposed Amendment to N.Y. Mental Hygiene Law § 9.01

The Governor's proposed amendment to MHL § 9.01 rests on a redefinition of the term "likelihood to result in serious harm" or "likely to result in serious harm." Those defined terms provide the operative standard that underpins all of the provisions of the Mental Hygiene Law governing involuntary and emergency psychiatric admissions.[12]

Section 9.01(a) currently provides that the "risk of physical harm to the person" must be "manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself."

As proposed, the new MHL§ 9.01 defines "likelihood to result in serious harm" or "likely to result in serious harm" to also include "a substantial risk of physical harm to the person due to an inability or refusal, as a result of their mental illness, to provide for their own essential needs such as food, clothing, medical care, safety, or shelter."[13]

This definitional change is intended to incorporate the 2022 guidance issued by OMH, at the Governor's behest in connection with Governor Hochul's and Mayor Adams' unveiling of their joint plan to roust people from the New York City subway system (the "OMH Guidance").[14] The OMH Guidance is built on case law that has determined only the due process implications of inpatient clinical assessment practices. Permitting this definition to govern law enforcement interactions on the street, or in the subway, is inappropriate.[15]

The OMH Guidance incorrectly states that "it is now well settled law that an inability to meet one's need for food, clothing or shelter is sufficient to establish dangerousness to self **for purposes of removal from the community for assessment and involuntary admission**" (emphasis supplied).

The law is in fact settled that in order to satisfy substantive due process requirements, "the continued confinement of an individual must be based clear and convincing evidence that the person is mentally ill and that he poses a substantial threat of physical harm to himself (resulting) from a refusal or inability to meet his essential needs for food, clothing or shelter." *Boggs v. Health Hosps. Corp*., 132 A.D.2d 340 (1st Dept. 1987); *In re Application of Consilvio v. Diane W*., 269 A.D.2d 310 (1st Dept. 2000); *Matter of Carl C*., 126 A.D.2d 640 (2d Dept 1987); *Matter of Scopes v. Shah*, 59 A.D.2d 203 (3d Dep't 1977).

The law is also quite well settled that due process will not tolerate a person's involuntary commitment irrespective of whether treatment some may deem beneficial will be provided. *See O'Connor v Donaldson*, 422 U.S. 563, 576 (1975); *Project Release v Prevost*, 551 F. Supp. 1298, 1304 (E.D.N.Y. 1982*), aff'd* 722 F.2d 960 (2d Cir. 1983); *Matter of Scopes*, 59 A.D.2d at 205).

Contrary to OMH's representations, no court has ever determined the propriety of the use of the inability/failure to meet essential needs standard for purposes of a person's "removal from the community for assessment and involuntary admission" by law enforcement personnel. And the caselaw OMH has cited in favor of that proposition only addresses inpatient commitment and inpatient treatment situations.

In medicine, the first step is an accurate scientifically valid, fact-based diagnosis. Yet many mental health conditions require physicians to rely on more subjective criteria such as observation of symptoms or behaviors, such as self-neglect. This opens the door for cognitive biases and external factors to influence medical assessments. Mental health professionals are trained to guard against such disparate influences when they review clinical evidence regarding a patient's symptoms and medical history and to evaluate the trustworthiness, validity and relevance of any other information gathered about a patient.[16]

Law enforcement personnel generally receive very rudimentary conceptual disability training when they come through police academy. In connection with the roll out of Mayor's Adams 9.41 sweeps initiative in November 2022, the NYPD offered a one-time power-point training on the OMH guidance which was initially delivered at precinct roll calls but which was stopped after the NYPD developed a training video for officers to supplement their academy training and to view at their own discretion.[17] Law enforcement personnel are not – nor are they capable of filling the role of – clinicians and there is no trained clinician present during the mental hygiene arrest process – in that person's home on in a street or subway interaction with that person – where the assessment contemplated in proposed MHL § 9.04 is made.

Applying this standard to permit law enforcement to effect a mental hygiene arrest and to "remove a person from the community for assessment and involuntary admission," would result in erroneous hospitalization of non-dangerous and non-mentally ill individuals—an unconstitutional deprivation of individual liberty.[18] The Governor's proposed alteration to § 9.01 will inevitably open the door to significant and protracted litigations in the federal and New York State Courts.

For all of these reasons, the Governor's proposed amendments to Mental Hygiene Law § 9.01 (and by extension, the entirety of Mental Hygiene Law Article 9) should be rejected.

B. Proposed Amendments to N.Y. Mental Hygiene Law § 9.60, Kendra's Law

In 1999, the New York legislature adopted Mental Hygiene Law § 9.60, commonly referred to as Kendra's Law or "AOT" (assisted outpatient treatment). Kendra's Law expanded the circumstances under which the State may compel persons with psychiatric disabilities to undergo treatment against their will or to participate involuntarily in mental health programs even if those individuals do not meet the criteria for involuntary hospitalization and/or medication. In enacting Kendra's Law, "(c)learly, the Legislature was concerned with the 'merry-go-round' of patients who would stabilize in the hospital, only to decompensate because of a later failure to comply with outpatient treatment, causing rehospitalization." *In re Weinstock,* 191 Misc. 2d 143 (Sup. Ct. N.Y. County 2002). In justifying overriding the fundamental right of a person to determine his or her course of medical treatment,[19] the courts have noted that the Legislature found:

> "there are mentally ill persons who are capable of living in the community with the help of family, friends and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization. The legislature further finds that there are mentally ill persons who can function well and safely in the community with supervision and treatment, but who without such assistance, will relapse and require long periods of hospitalization.
>
> "The legislature further finds that some mentally ill persons, because of their illness, have great difficulty taking responsibility for their own care, and often reject the outpatient

> treatment offered to them on a voluntary basis. Family members and caregivers often must stand by helplessly and watch their loved ones and patients decompensate. Effective mechanisms for accomplishing these ends include: the establishment of assisted outpatient treatment as a mode of treatment; improved coordination of care for mentally ill persons living in the community; the expansion of the use of conditional release in psychiatric hospitals; and the improved dissemination of information between and among mental health providers and general hospital emergency rooms."

In re Urcuyo, 185 Misc. 2d 836, 714 N.Y.S.2d 862 (Sup. Ct. N.Y. County 2000)(*citing* L 1999, Ch 408, § 1).

Involuntary outpatient commitment orders under §9.60 ("§9.60 orders" or "Kendra's law orders") typically involve judicial decrees that compel the administration of psychotropic drugs and require participation in other mental health services. These orders are intrusive invasions of personal liberty and bodily integrity. According to the New York State Office of Mental Health, § 9.60 orders determine what medications a people must take; where they receive therapy, spend much of the day (day treatment or rehabilitative programs) and even live (such as a community residence with a curfew and many rules); and whether and when they submit to blood and urine testing.[20] Since 1999, there have been 35,040 orders, of the 36,694 petitions filed, entered statewide.[21]

In order to obtain a Kendra's law order, the court must first determine, by clear and convincing evidence, that:

- the individual has a history of noncompliance with treatment that has led to at least two hospitalizations or one or more acts of serious violent behavior or threats of, or attempts at, serious physical harm (§ 9.60 (c) (4));
- the individual is not likely to voluntarily comply with treatment in the absence of a Kendra's law order (§ 9.60 (c) (5));
- in view of this history, the individual "is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others" (§ 9.60 (c) (6));
- it is likely that the individual will benefit from assisted outpatient- treatment (§ 9.60 (c) (7)); and
- assisted outpatient treatment is the **least restrictive alternative** for the individual (§ 9.60 (j) (2)) (emphasis added).

During the 2022-2023 legislative session, state lawmakers amended Kendra's Law in ways that drift significantly away from the statutory regime that underpinned the New York Court of Appeals' 2004 decision upholding Kendra's Law against constitutional challenge. Kendra's Law was amended to add a new subparagraph (iii) to § 9.60(c)(4) that provides for an expired Kendra's law order to be revived on the decidedly vague basis that "the person has experienced a substantial increase in symptoms of mental illness" which "symptoms substantially interferes with or limits one or more major life activities" – vague language which also falls well below the very high standard for subjecting an individual to involuntary treatment. The amendment also allows doctors to merely make virtual court appearances, § 9.60(h), upon a showing that both diligent efforts have

been made to attend such hearing in person and that the subject of the petition has consented to the physician's remote testimony.

The Governor's budget proposes to amend the standard for likelihood of serious harm to include attenuated claims of a person's inability or refusal to provide for their basic needs in § 9.60(c)(6). The Governor also now proposes to further amend the completely vague standard for reinstatement of an expired Kendra's Law order in § 9.60 (c)(4)(iii), a change that introduces the unconstitutionally vague and improperly broad standard that the person has experienced a substantial increase in symptoms that substantially interfere or limit the person's "ability to maintain their health or safety."

The Governor also proposes to remove the minimal due process guardrails that the testifying clinician had to demonstrate good faith efforts to appear in person and that the person who is the subject of a Kendra's law petition has to consent to the video conference appearance by the clinician. "In almost every setting where important decisions turn on questions of fact, due process requires an opportunity to confront and cross-examine adverse witnesses." *Goldberg v. Kelly*, 397 U.S. 254, 269 (1970). The Confrontation Clause mandates that a criminal defendant has the right to confront and cross-examine the witnesses against him. *See Pennsylvania v. Ritchie*, 480 U.S. 39, 51 (1987). This generally means that out-of-court testimonial statements by a witness are not admissible against a defendant unless the witness is available for cross-examination at trial or the defendant had an opportunity to cross-examine the witness about the statements before trial. *Crawford v. Washington*, 541 U.S. 36, 53-54 (2004). Presently neither the Supreme Court nor the Court of Appeals has clearly established that the Sixth Amendment right to confront and cross-examine witnesses attaches in involuntary civil commitment proceedings. But, under the principles of due process, a person facing a commitment process may very well be deemed to have the right to confront the witnesses against them due to the heightened risk of deprivation of individual liberty.

In re K.L., N.Y.3d 362, 366 (2004) marked the end point in constitutional challenges to "Kendra's Law." For the reasons set forth above, the Governor's proposed amendments to "Kendra's Law" will reopen the door to new constitutional challenges.

Accordingly, we respectfully urge you to reject these proposed significant changes to MHL § 9.60.

II. Interstate Nurse Licensure Compact for RNs and LPNs

HMH Part W would make New York State a party to the Interstate Nurse Licensure Compact. The proposed legislation is lodged in the HMH bills and has been touted as providing a way to enhance the dire nursing workforce shortages being experienced by OMH, OPWDD and OASAS.

While participation in these compacts carries benefits– namely, it may facilitate more providers becoming licensed to practice in New York State – it also presents significant risks to New York's ability to protect reproductive and gender-affirming care providers from investigation, professional discipline, and potentially prosecution by other states. The compact language requires member states to participate in information exchanges, reciprocal disciplinary schemes, and mutual subpoena enforcement, which could complicate the application of New York's recently enacted shield laws. Our shield laws are designed to ensure that New York State is not complicit in any attempts to punish those who provide, receive, or support access to reproductive and

gender-affirming care by New York providers, including by preventing the state from cooperating with investigations, domesticating subpoenas, or pursuing professional discipline against providers related to their provision of reproductive or gender-affirming care. However, by participating in an interstate compact, New York would be bound to comply with compact provisions that may come into conflict with these shield law prohibitions, thereby undermining the state's ability to protect providers.

The NYCLU recognizes that New York State faces a shortage of health care providers serving the many thousands of people receiving services in the OMH, OPWDD and OASAS service delivery systems, as well as a shortage of sexual and reproductive health care providers, without whom we cannot maintain a well-functioning, equitable health care system. We would encourage the legislature to weigh the serious risks inherent in joining any interstate nursing licensure compact.

III. OPWDD Managed Care Statute Extender

OPWDD should not be permitted to spend another two years determining whether New Yorkers with intellectual/developmental disabilities (I/DD) should be pushed into long managed care as is proposed in HMH Part CC. On behalf of the almost 1800 Willowbrook class members, living in OPWDD group homes and other residential settings around the state, the NYCLU urges the Legislature to reject the latest two-year extension of the authorization to move the system of services for people with to Medicaid managed care.[22]

One of former-Governor Andrew Cuomo's first acts when elected governor was to establish a Medicaid redesign team that recommended, among other proposals, the adoption of a managed-care model for delivery of long-term services to all New York State Medicaid beneficiaries with disabilities. This service delivery model is intended to replace the traditional fee-for-service model that has long been used for delivery of services to the individuals receiving Medicaid-funded services.

Two principal factors motivated New York's movement into risk-based managed care for Medicaid beneficiaries with disabilities. First, New York sought both to reduce Medicaid spending, and to make such expenditures more predictable. Second, the state claimed it wanted to improve the delivery and quality of care, particularly for individuals who require complex and costly services. But for over a decade, the state has made significant changes to managed care under the guise of reform and terminated, reduced or eliminated critical services for an untold number of New Yorkers.[23] New Yorkers with I/DD have been exempted from the mandate that the OPWDD services delivery system be converted into a risk-based managed care.

The most recent report commissioned by OPWDD evaluating whether or not New Yorkers with I/DD should be forced into managed long-term care by their latest, well-compensated outside consultant, Guidehouse, actually did "**NOT** recommend a transition to full managed care for the whole OPWDD service delivery system." Rather, Guidehouse suggested that OPWDD "focus on improving its current system and processes rather than moving forward with a comprehensive change to the current service delivery system by implementing managed care for all services." *See New York State Office for People With Developmental Disabilities (OPWDD) Managed Care Assessment Final Report*, available at https://opwdd.ny.gov/news/opwdd-issues-final-report-managed-care-assessment (last accessed February 3, 2025).

Risk-based managed care for New Yorkers with I/DD is inappropriate for a number of reasons. First, when delegating functions to a managed care organization, New York cannot cede its obligations under the state constitution to vulnerable individuals with I/DD who require long-term services. The State must ensure that constitutionally mandated services and care is provided. What is more, New York is required under federal Constitutional law, and Medicaid standards, to ensure that services provided to Medicaid beneficiaries with disabilities are responsive to the individual choice of these individuals and that these services are based upon a "person-centered" plan and delivered in the least restrictive setting appropriate to an individual's needs. Cost-containment standards may lead to the institutionalization of persons for whom community-based services is the appropriate setting.

Second, New York has been exploring the possibility of managed care for people with I/DD for over ten years and there has been no conclusive evidence such a move would, in fact, improve coordination of care, access to enhanced services or even improve the lives of people with I/DD. Studies from other states have already conclusively demonstrated that there are no savings associated with managed care for long term supports and services for people with I/DD and, certainly, there is no evidence of improvements to access to services or quality of services.

While New York State may consider that moving the I/DD population into a managed care system will control costs and even effectuate cost savings, there is very limited data to demonstrate that implementing managed care for the I/DD population will actually produce any savings. In 2019, the Texas Health and Human Services Commission engaged Deloitte Consulting LLP ("Deloittte") to evaluate the cost-effectiveness of transitioning the Texas fee for service programs for I/DD LTSS to managed care.[24] Deloitte conducted extensive research and collection of publicly available data from other states that have experience with I/DD MLTSS to inform their assessment of the potential fiscal impacts in Texas. Deloitte concluded, amongst other things, as follows:

> While general increased access to care could decrease expenditures through improved health outcomes for members, it is not apparent that the increase in access is consistent across all populations and managed care programs. Similar to the findings on access to care, cost data on quality outcomes are not readily available and have varied results. Over the past several years, some small case studies have indicated improved quality and outcomes in managed care with care management techniques by plans. Research conducted in five states that have implemented managed care programs indicated that "anecdotal evidence suggests" savings could be realized through implementation of effective care management techniques. Limited research has been conducted with people with more complex needs, however, such as individuals with I/DD and older persons. [25]

The OPWDD service delivery system is confronting a critical shortage of staff; an inability to serve those with complex needs; a shortage of residential opportunities; a growing population of unserved and underserved; and an aging population requiring more services. The transition to managed care for people with I/DD certainly does not appear to address any of these critical systemic challenges and, indeed, may exacerbate these issues.

As both OPWDD, and DOH, are aware, the ongoing uncertain rollout of the Medicaid managed care and the "rate rationalization" system, which DOH and OPWDD negotiated with CMS have resulted in increasing uncertainty in the OPWDD service system and significant changes to the quality and range of services afforded people who require OPWDD's services. The COVID-19 pandemic only led to further deterioration in the residential providers' fiscal circumstances and ongoing destabilization of the service delivery system.

Extending OPWDD's authorization to continue to "study and explore" long term managed care will only result in delaying any effort to implement other changes to the service system in order to ensure the needs of people with I/DD and the workforce supporting them will be met.

IV. Recommendations

We offer a number of recommendations for the Legislature to consider concerning alternative evidence-based programs and other initiatives that will strengthen the public mental health system's ability to respond to the needs of individuals with serious mental illness.[26] As noted above, our recommendations fall into several categories, encompassing oversight and accountability measures, housing, peer services and family support programs, consensual care delivery accomplished by way of enhanced voluntary services packages in lieu of involuntary outpatient commitment orders, expansion of community-based preventative services offered by the Assertive Community Treatment (ACT) and Forensic ACT teams; as well as workforce support and workforce development measures.

We are not the only ones espousing these successful evidence-based programs and initiatives. The Bazelon Center issued a report objecting to the Adams Administration's mental health involuntary removals policy that provides citations to a raft of research that indicates the success to be found with high-quality engagement of homeless people with mental health conditions.[27] One such successful approach is that deployed by the New York's Street Homeless Advocacy Project, a peer-led street engagement process that has successfully connected street homeless people to supportive services.[28] Safe, stable, and affordable housing, provided with voluntary supports, has always been shown to help unhoused New Yorkers with mental health challenges, and others, stabilize and avoid hospitalization and incarceration.[29] A menu of longer-term services, such as assertive community treatment (ACT), supported employment, and peer support services—delivered not in the hospital, but in the person's own home and community—have been shown to break the cycle of institutionalization.[30] Low barrier/no barrier supportive housing is also a critical part of the equation.[31]

We also respectfully direct the Legislature's attention to a comprehensive report from the United States Interagency Council on Homelessness titled *All In: The Federal Strategic Plan to Prevent and End Homelessness*.[32] The Interagency Council notes that local officials have responded to a rise in the number of people living in unsheltered locations "not always in the most effective ways" through "out of sight, out of mind" policies that displace people without successfully connecting them to evidence-based services.[33] This is precisely a description of the City's NYPD-led homeless sweeps initiatives to date, initiatives that clearly fall within the parameters of criminalization of homelessness which the Interagency Council notes is a completely counterproductive approach to a pressing social issue.

Importantly, these "out of sight out of mind" policies take away resources from constructive solutions to homelessness, create trauma, can erect financial and criminal legal barriers for people seeking pathways out of housing insecurity and homelessness, and disproportionately burden already-marginalized communities including people of color, LGBTQI+ people and people with disabilities.[34]

Rather than expanding involuntary commitment and forced treatment, we urge prioritization of the following policies and investments:

Implement Incident Review Panels

When system breakdowns occur that result in violence and tragic outcomes, it is critical that the State assess what went wrong and evaluate how such incidents can be prevented going forward. Incident review panels are currently authorized by MHL § 31.37 but have never been implemented. Such panels should be made mandatory, and there should be public reporting of the systemic gaps and corrective actions taken.

Increase funding for the Empire State Supportive Housing Initiative (ESSHI) and expand Housing First programs

The base ESSHI rate must be raised as the Governor's proposed enhancement is insufficient.

Expand Housing First programs by adding significantly more Housing First units statewide.

Expand Peer Services and Family Support programs for Individuals with Serious Mental Illness (SMI)

The Governor proposes to fund only three INSET peer-to-peer, person-centered outreach and engagement teams that are demonstrating strong success in engaging people with major mental illnesses who are currently disconnected from services and who might otherwise have been placed on an involuntary outpatient commitment order (sometimes referred to as Assisted Outpatient Treatment or AOT). At least five more INSET teams should be funded in regions that currently do not offer this pivotal service.

The Governor's budget proposes to fund only two Peer Bridger teams. Since 1994, Peer Bridgers have helped thousands of individuals to successfully transition from state hospitals to the community. Peer Bridger teams should be routinely included as a part of successful hospital discharge plans that prevent high numbers of avoidable relapses and repeat readmissions. At least five more Peer Bridger teams should be funded.

Direct support services to families must be expanded.

Enhanced Voluntary Service Packages

The Governor's budget proposes to increase Involuntary Outpatient Commitments and to fund enhanced voluntary service packages, which provide a voluntary alternative to Involuntary Outpatient Commitments, and are equally effective. The Legislature must

restrict this funding solely to enhanced voluntary service packages, and not to the expansion of Involuntary Outpatient Commitments.

Assertive Community Treatment (ACT) and Forensic ACT

ACT and Forensic ACT provide intensive, evidence-based care to individuals with serious mental illness in the community. Research finds they reduce hospitalizations and emergency room visits and increase housing and employment, with Forensic ACT teams also reducing criminal legal system involvement. Forensic ACT must be funded to provide services on a statewide basis. ACT should also be expanded to eliminate the waitlist for services, which is six months to one year in New York City and longer in other parts of the state.

Workforce support/development

The Governor's budget proposes only a 2.1% investment. That is woefully inadequate. Programs are not able to attract and retain qualified staff without sufficient resources.

Update Temporary Disability Insurance (TDI)

Most New Yorkers do not have the ability to take time off from work to address their own serious health needs – whether due to mental health challenges, to undergo cancer treatments, recover from major injuries or illnesses, or to prevent or recover from a pregnancy loss or neonatal loss – without risking their economic security and taking the chance that they will not have a job to return to. That is because New York's Temporary Disability Insurance (TDI) program that provides medical leave benefits to New Yorkers who need time off from work to tend to their own health needs has been capped since 1989 at $170/week – far below cost of living in 2025 – and it does not include job protection.

Updating TDI was on the table in last year's budget negotiations but fell out at the last minute. Still, the Assembly and Senate came to a compromise that the Senate passed at the end of the 2024 state legislative session. Unfortunately, the Assembly ran out of time. The compromise will remove the $170/week cap on medical leave benefits and align the first twelve weeks of medical leave benefits with the more generous benefits the state offers New Yorkers who need paid family leave. It will also build a pathway for the Workers' Compensation Board to align medical leave benefits for the remaining fourteen weeks of TDI with paid family leave's more generous benefits. It will phase-in the medical leave increase in a progressive way that will enable low-income workers to access the program sooner. And for those who need to access New York's TDI program, it will ensure job protection and continuity of health insurance – necessary benefits already provided to those who take paid family leave.

Importantly, the compromise also includes intermittent leave for anyone who needs it to address their own serious health needs. This option is already available to those who need paid family leave. Intermittent leave is particularly critical for people going through cancer or mental health treatments, who may need a day off to undergo treatment and then be able to work normally for a period of weeks before needing another day for treatment. It is equally important for those struggling with ME-CFS, Long COVID, or another fatiguing condition, who may need to phase-in a return to work, and for those experiencing a

complicated pregnancy, who may need bedrest for a week at a time a few different times during a pregnancy, among many others.

Updating New York's medical leave program is a gender and racial justice imperative. The United States faces a maternal health crisis that disproportionately impacts Black women.[35] New York has seen a quadrupling of the maternal mortality rate for Black women in the last seven years.[36] The compromise will ensure that pregnant New Yorkers can afford to take time off to keep themselves and their pregnancies healthy, without risking economic insecurity. And, if a person experiences pregnancy loss, it will ensure that they can take job-protected leave to recover without sacrificing their income. Perversely, under current law, when a person experiences a pregnancy complication or loss, they are not able to take leave without losing their income and risking their job. But a family member can take job-protected leave with a sustainable wage to care for them.

The legislature must show its support for all New Yorkers, including pregnant workers, workers with disabilities, workers who struggle with substance use, and workers living with Long COVID, by including the TDI compromise, S.172/A.84, in its one house budget proposals and ensuring that it becomes law in the FY2026 enacted budget.

MHANY's 10-Point Plan[37]

We urge the Legislature to consider the additional recommendations set forth in MHANY's recently issued 10-point plan that aims to close the gaps in mental health services delivery, including crisis response.

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The NYCLU thanks the Legislature for the opportunity to provide testimony and for your work on the budget. We thank you for your continued leadership in addressing New York's mental health crisis. We look forward to discussing with you how the budget can best invest in the care New Yorkers need, and the safety New Yorkers deserve. We are also available to discuss additional evidence-based programs and other initiatives that will strengthen the public mental health system's ability to respond to the needs of individuals with serious mental illness.

ENDNOTES

[1] *See, e.g., Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983). In *Project Release*, the federal Second Circuit Court of Appeals upheld the constitutionality of New York's voluntary, involuntary, and emergency commitment procedures contained in Article 9 of the Mental Hygiene Law. The Second Circuit concluded:

> We are acutely aware of the severe curtailment of liberty which involuntary confinement in a mental institution can entail, and of the process that must be accorded to those who may be affected by such action of the state. We are also mindful of the state interests served in providing care for those in need of treatment for mental illness and in maintaining order and preventing violence to

> self and others. With these concerns in mind, and having considered the New York M.H.L. in its entirety, our inquiry leads us to conclude that the statute does meet the minimum facial requirements of due process — both substantive and procedural.

Id. at 975. The NYCLU litigated *Project Release.* The NYCLU also litigated the *Boggs* case referenced above.

See also In re K.L., 1 N.Y.3d 362, 366 (2004). In *K.L.*, the Court of Appeals determined that the state's *parens patriae* interest in providing care to its citizens who are unable to care for themselves because of mental illness is properly invoked since a Kendra's Law order requires, by clear and convincing evidence, findings that the patient is unlikely to survive safely in the community without supervision; the patient has a history of lack of compliance with treatment that has either necessitated hospitalization or resulted in acts of serious violent behavior or threats of, or attempts at, serious physical harm; the patient is unlikely to voluntarily participate in the recommended treatment plan; the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others; and it is likely that the patient will benefit from assisted outpatient treatment. In requiring that these findings be made by clear and convincing evidence and that the assisted outpatient treatment be the least restrictive alternative, the statute's procedure for obtaining an AOT order provides all the process that is constitutionally due.

The NYCLU was actively involved in the drafting, and passage, of "Kendra's Law." The NYCLU, with others, also challenged the constitutionality of "Kendra's Law" shortly after the law was enacted. The NYCLU participated as *amicus curiae* counsel in a predecessor litigation, *In re Urcuyo*, 185 Misc. 2d 836, 714 N.Y.S.2d 862 (Sup. Ct. N.Y. County 2000).

[2] MHL § 31.37 provides as follows:

> **(a)** The commissioner is authorized to establish, on his or her own accord or pursuant to a request by a local governmental unit, a mental health incident review panel for **the purposes of reviewing** in conjunction with local representation, **the circumstances and events related to a serious incident involving a person with mental illness.** For purposes of this section, a "serious incident involving a person with mental illness" **means an incident occurring in the community in which a person with a serious mental illness suffers physical injury as defined in subdivision nine of section 10.00 of the penal law or causes such physical injury to another person, or suffers a serious and preventable medical complication or becomes involved in a criminal incident involving violence.** A panel shall be authorized to conduct a review of such serious incident in an attempt to **identify problems or gaps in mental health delivery systems and to make recommendations for corrective actions to improve the provision of mental health or related services, to improve the coordination, integration and accountability of care in the mental health service system, and to enhance individual and public safety.**

(emphasis supplied). MHL § 31.37 was finally, and reluctantly, enacted in 2013 in accord with a 2008 recommendation emanating from a joint New York State/New York City Task Force convened in the wake of a series of horrific acts of violence committed by and against people with mental illness. *See New York State/New York City Mental Health Criminal Justice Panel Report and Recommendations to Governor David A. Paterson and Mayor Michael R. Bloomberg,* June 2008, available at https://www.criminaljustice.ny.gov/pio/mh-cjreport.pdf (last accessed February 3, 2025).

This 2008 Task Force "focused on opportunities to improve services for the subset of individuals with serious mental illnesses who are at risk of poor treatment outcomes, violence, and involvement with the

justice system. This targeted focus is supported by an extensive body of research indicating that the vast majority of those with mental illnesses are not violent, and that mental illness is not a major driver of violent crime-in fact, studies show that individuals with mental illnesses are far more likely to be victims of violence than the general population. Research does suggest, however, that the risk of violence is significantly increased among individuals with mental illnesses who do not receive adequate mental health care, and considerably more so among those individuals with co-occurring mental health and substance use disorders."

[3] *See The State of Mental Health of New Yorkers,* New York City, Department of Health and Mental Hygiene, May 31, 2024, available at https://www.nyc.gov/site/doh/about/press/pr2024/nyc-releases-first-ever-state-of-mental-health-report.page (last accessed February 3, 2025).

[4] Mayor Adams, for example, continuously refers to the City's "two 'Top 50' lists**,** which track homeless New Yorkers well-known to service providers for the severity of their needs and their long-lasting resistance to help." *See, e.g.,* Maya Kaufman, Jeff Coltin, Emily Ngo, Nick Reisman, *Hospitalizing the mentally ill, a year later,* Politico 11/29/2023 07:05 AM EST, available at https://www.politico.com/newsletters/new-york-playbook/2023/11/29/hospitalizing-the-mentally-ill-a-year-later-00129012 (last accessed February 3, 2025). And Brian Stettin, Adams' senior adviser on severe mental illness, "says those are exactly the people the city wanted to help, but who previously were neglected by the health and social services system, unless they committed an act of overt violence." *Id.*

[5] The Adams Administration has recently tried to avoid the mental hygiene arrest nomenclature. According to the Mayor's Office of Community Mental Health (MOCMH) 2024 Involuntary Transports Annual Report, available at https://mentalhealth.cityofnewyork.us/issue-briefs-and-reports (last accessed February 3, 2025):

> **Involuntary transport is a process by which an individual is taken into custody** for the purpose of transportation to a hospital for psychiatric evaluation. **It does not constitute an arrest,** as it is not related to criminal charges, but rather is aimed at protecting the person and addressing immediate mental (and sometimes physical) health needs.

It is well settled that for involuntary removals under Section 9.41 of the MHL, "courts apply the same concepts of probable cause and objective reasonableness as in criminal cases to determine whether the confinement is privileged because the plaintiff's behavior was likely to result in serious harm." *Greenaway v. County of Nassau*, 97 F. Supp. 3d 225, 233 (E.D.N.Y. 2015). In doing so, courts treat involuntary removals as "the functional equivalent of [] arrest[s]," *Disability Advocates., Inc. v. McMahon*, 279 F. Supp. 2d 158, 168-69 (N.D.N.Y. 2003), *aff'd,* 124 F. App'x 674 (2d Cir. 2005). Probable cause for a MHL § 9.41 mental hygiene arrest only "exists if there are reasonable grounds for believing that the person seized is dangerous to herself or to others." *Guan v. City of New York*, 2020 WL 6365201 (S.D.N.Y. Oct. 29, 2020), *aff'd on other grounds*, 37 F.4th 797 (2d Cir. 2022) (internal citation and quotation omitted); *Anthony v. City of New York*, 339 F.3d 129, 142 (2d Cir. 2003) (citation omitted). The Second Circuit has cautioned, in a case concerning the mental hygiene arrest of a woman for psychiatric evaluation, that evidence that the woman appeared irrational, annoyed, and very uncooperative, without more, was insufficient to infer that she was dangerous and, thus, establish probable cause for arrest. *Myers v. Patterson*, 819 F.3d 625, 632 (2d Cir. 2016).

The City's effort to differentiate "taken into custody" by law enforcement from an "arrest" is a blatant effort to sanitize what actually occurs when NYPD takes a person into "custody" for purposes of involuntary transport to a CPEP or E/R. A person taken into "custody" is not free to leave, the person is in police detention. Even if a person is unarmed, not violent and willing to leave voluntarily, the NYPD must take the person into "custody." The police officer must activate their body worn camera and carries, in

addition to their service weapon and taser, a three-foot polycarbonate shield for protection. The person in "custody" is routinely frisked and their property routinely searched. Use of force, from "less lethal" devices (such as a taser), all the way to lethal use of force is authorized to be used by the police officer who has the person in "custody." The custodial police officer may use "restraining equipment" such as handcuffs, spit hoods, body bags, on the person in their "custody." See NYPD Voluntary/Involuntary Transports Roll Call Training Slide Deck, produced under FOIL to the NYCLU by NYPD on 5/26/2023 (on file with the NYCLU). *See also* NYPD Patrol Guide Policy 221-13, available at Patrol Guide Vol. 4, https://www.nyc.gov/site/nypd/about/about-nypd/manual.page (last accessed February 3, 2025).

[6] *See Mayor Adams Announces More Than Half of Hardest-to-Reach New Yorkers Have Moved From Street Into Care One Year After Severe Mental Illness Plan Launches,* November 29, 2023, available at https://www.nyc.gov/office-of-the-mayor/news/907-23/mayor-adams-more-half-hardest-to-reach-new-yorkers-have-moved-street-into#/0 (last accessed February 3, 2025). *See also* Annie McDonough, *Involuntary removals steady over last year under Adams policy,* City and State New York, September 3, 2024, available at https://www.cityandstateny.com/policy/2024/09/involuntary-removals-steady-over-last-year-under-adams-policy/399261/ (last accessed February 3, 2025).

[7] Judge David L. Bazelon Center for Mental Health Law, *Mayor Adams' Plan Will Not Help New Yorkers With Mental Disabilities*, December 22, 2022, available at http://www.bazelon.org/wp-content/uploads/2022/12/BC-NYC-Statement-12-2-22.pdf (last accessed February 3, 2025). *See also* Center for Court Innovation, *The Myth of Legal Leverage?* ("Studies of therapeutic intervention strongly suggest that the quality of the human interaction outweighs the importance of any particular protocol or approach…." "factors like goal consensus, empathy, alliance, and positive regard are significantly greater than, say, model fidelity," and "a robust therapeutic relationship is less a matter of dosage and more a matter of engagement."), available at https://www.courtinnovation.org/sites/default/files/media/documents/2020-04/report_the_myth_of_legal_leverage_04232020.pdf (last accessed February 3, 2025).

[8] Many Task Forces have been convened over the years since the Mental Hygiene system was reorganized in 1978 into the autonomous Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse (OASAS), and the Office for People with Developmental Disabilities (OPWDD). Regrettably, however, the many significant and thoughtful recommendations emanating from these task forces, even those convened by the Legislature itself, have largely been disregarded by various Governors and members of this legislative body.

See, e.g. An Evaluation of the Delivery of Mental Hygiene Services in New York State: A Report by the Mental Hygiene Task Force to Assemblyman Peter M. Rivera Chair of the New York State Assembly Standing Committee on Mental Health, Mental Retardation and Developmental Disabilities, February 2005, available at https://assembly.state.ny.us/comm/Mental/20050303/ (last accessed February 3, 2025). This 2005 report was issued by a "statewide mental hygiene work group to help chart a new direction for New York's crisis plagued mental health system [whose] recommendations]…] are important first steps in rebuilding a system that many feel has lost focus of its humanitarian mission."

See also New York State/New York City Mental Health Criminal Justice Panel Report and Recommendations to Governor David A. Paterson and Mayor Michael R. Bloomberg, June 2008, *supra,* available at https://www.criminaljustice.ny.gov/pio/mh-cjreport.pdf (last accessed February 3, 2025)."

[9] 14 NYCRR 590.8(h) provides as follows:

(h) Discharge criteria.

The provisions of section 29.15 of the Mental Hygiene Law shall not apply to the discharge of an individual from a comprehensive psychiatric emergency program, however:

(1) Discharge planning shall be conducted for all persons discharged from a comprehensive psychiatric emergency program who have been determined to require additional mental health services after triage and referral or full emergency visit and for those persons admitted to extended observation beds who require additional mental health services.

In layman's terms, this means that any person brought in by law enforcement, or otherwise, who just gets a brief triage evaluation and referral gets no discharge planning, i.e. no connection to supports and services in the community and no communication/hand off to any community-based providers who may be providing services to that person. And for those people who are deemed to require additional mental health services after a full emergency visit or who are admitted to extended observation beds and are discharged, they get only a form of discharge planning "light." OMH, in conjunction with the NYS Department of Health, has issued multiple rounds of intensely complex discharge planning guidance – guidance that is quite proscriptive and somewhat quite useful, but which we understand anecdotally, is generally not followed in the field. Of course, when there are no services available to connect a person to, the facilities providing "light" touch discharge planning is hobbled in ensuring that person's safety, as well as community safety. *See e.g. Guidance on Evaluation and Discharge Practices for Comprehensive Psychiatric Emergency Programs (CPEP) and §9.39 Emergency Departments (ED) October 2023,* available at https://omh.ny.gov/omhweb/guidance/omh-doh-evaluation-discharge-guidance.pdf (last accessed February 3, 2025); *see also Guidance for Outpatient Treatment, Residential, Residential Treatment Facility, and Care Management Programs on Collaborating with Hospitals on Admissions and Discharges to Support Recovery-focused System Change, October 2024,* available at https://omh.ny.gov/omhweb/guidance/outpatient-programs-collaborating-with-hospitals-on-admissions-discharges-guidance.pdf (last accessed February 3, 2025).

[10] *See* Ghiasi N, Azhar Y, Singh J. *Psychiatric Illness and Criminality*. (Updated 2022 Jan 15), available at https://www.ncbi.nlm.nih.gov/books/NBK537064/ (last accessed February 3, 2025), noting that "[w]hile the renewed focus and media attention on the importance of mental health in the aftermath of such tragedies is a positive development, the relationship between mental illness and criminality is too often conflated. The popular belief is that people with mental illness are more prone to commit acts of violence and aggression. The public perception of psychiatric patients as dangerous individuals is often rooted in the portrayal of criminals in the media as "crazy" individuals. A large body of data suggests otherwise. People with mental illness are more likely to be a victim of violent crime than the perpetrator. This bias extends all the way to the criminal justice system, where persons with mental illness get treated as criminals, arrested, charged, and jailed for a longer time in jail compared to the general population."

[11] Governor Hochul and Mayor Adams have routinely noted that the administration has a "moral obligation" to connect severely mentally ill New Yorkers to appropriate care and housing.

The NYCLU, and likely everyone the Legislature will hear from, agree completely with this unremarkable statement. Society's shared "moral obligation" derives in large part from the doctrine of *parens patriae*, a legal term referring to the power of the government to act on behalf of people who are unable to care for themselves. *Rivers v. Katz*, 67 N.Y.2d 485, 496-97 (N.Y. 1986). Indeed, Article XVII of the New York State Constitution, the "Social Welfare" provision of the state constitution, makes manifest the government's inherent *parens patriae* power with its mandate that New York must provide 'aid, care and support of the needy." NY Const art XVII § 1. Article XVII specifically includes those with mental illness and other disabilities. NY Const art XVII § 4.

But Governor Hochul and Mayor Adams proffer a second enormously troubling and retrogressive rationale. This rationale repeats unjustified and stigmatizing language that relies upon pernicious stereotypes and exacerbates bias – that New Yorkers who are unhoused and/or living with mental health challenges *per se* constitute a direct threat to the personal safety of others.

That a person is unhoused or living with mental health challenges is not indicative of dangerousness to others. Nor is an inability to meet one's own basic needs indicative of dangerousness to others. *See e.g. Violence and Victims: Exploring the Experiences of Violence Among Individuals Who Are Homeless Using a Consumer-Led Approach, Violence and Victims*, Volume 29, Number 1, 2014, https://nhchc.org/wp-content/uploads/2019/08/vv-29-1_ptr_a8_122-136.pdf(last accessed February 3, 2025).

Yet Governor Hochul, announcing the proposed 2025-2026 budget package directed at funding New York City's mental health services, intentionally stoked bias, conflating public discomfort with actual danger, in describing a public safety crisis stemming from a decades-long underfunding of mental health services and pointing to the public operating under "the fear of random violence or dodging someone in the midst of a mental health crisis [because] our subway [is] a rolling homeless shelter," full of persons "who are suffering from mental illness that is literally putting their lives and the lives of others in danger." *See Remarks as Prepared: Governor Hochul Delivers 2025 State of the State Address*, January 14, 2025, available at https://www.governor.ny.gov/news/remarks-prepared-governor-hochul-delivers-2025-state-state-address (last accessed February 3, 2025).

The Mayor's statements also continuously directly draw the line between mental illness and the conceit that there is an always present likelihood of violent acts directed by that person towards others:

> There's nothing dignified about using a corner of a tent as a restroom or having month-old food sitting there or talking to yourself, being delusional, or waiting until you carry out a dangerous act before we respond. That is just so irresponsible that **we know that this person is about to probably go off the edge and harm someone** but we're going to wait until it happened.

Address on the Mental Health Crisis in New York City, available at https://www.nyc.gov/office-of-the-mayor/news/871-22/transcript-mayor-eric-adams-delivers-address-mental-health-crisis-new-york-city-holds (last accessed February 3, 2025).

[12] The change to the definition of "likelihood to result in serious harm" or "likely to result in serious harm" set forth in § 9.01 changes multiple other provision of Article 9 of the Mental Hygiene Law. This term is used in the following sections of Article 9:

- § 9.37 - Involuntary admission on certificate of a director of community services or his designee.
- § 9.39 - Emergency admissions for immediate observation, care, and treatment.
- § 9.40 - Emergency observation, care and treatment in comprehensive psychiatric emergency programs.
- § 9.41 - Emergency admissions for immediate observation, care, and treatment; powers of certain peace officers and police officers.
- § 9.43 - Emergency admissions for immediate observation, care, and treatment; powers of courts.
- § 9.45 - Emergency admissions for immediate observation, care, and treatment; powers of directors of community services.
- § 9.57 - Emergency admissions for immediate observation, care and treatment; powers of emergency room physicians.
- § 9.58 - Transport for evaluation; powers of approved mobile crisis outreach teams.

- § 9.60 – Assisted Outpatient Treatment [Kendra's Law].

With the exception of § 9.41 which is the law enforcement-initiated mental hygiene arrest, there must be a clinical professional making the determination of the essential needs risk of harm.

[13] "Inability, or refusal … to provide for their own essential needs" is often referred to as "self-neglect." Self-neglect is a behavioral condition in which an individual neglects to attend to their basic needs, such as personal hygiene, appropriate clothing, feeding, or tending appropriately to any medical conditions they have. Self-neglect, except in its most severe manifestation which lends itself to a diagnosis of Diogenes syndrome, is not a mental illness, but it can be a symptom of various mental illnesses like depression, schizophrenia, bipolar disorder, dementia, and sometimes even personality disorders. Self-neglect can also be a sign of socio-economic challenges confronting a person. In fact, according to a 2023 study conducted on behalf of FPWA (the Federation of Protestant Welfare Agencies), more than seven million New Yorkers cannot provide for their basic needs. *See 2023 Center for Women's Welfare and FPWA, BRIEF ONE The Problem of Income Inadequacy in New York State*, available at https://www.fpwa.org/wp-content/uploads/2023/12/NY_FPWA_BriefOne.pdf (last accessed February 3, 2025).

[14] *See Interpretative Guidance for the Involuntary and Custodial Transportation of Individuals for Emergency Assessments and for Emergency and Involuntary Inpatient Psychiatric Admissions*, *to: NYS Public Mental Health Providers, From: Ann Marie T. Sullivan, MD, Commissioner, NYSOMH Thomas Smith, MD, Chief Medical Officer, NYSOMH, Date: February 18, 2022*, available at https://omh.ny.gov/omhweb/guidance/interpretative-guidance-involuntary-emergency-admissions.pdf (last accessed February 3, 2025). The Hochul/Adams Subway Safety Plan is available at https://www1.nyc.gov/assets/home/downloads/pdf/press-releases/2022/the-subway-safety-plan.pdf (last accessed February 3, 2025). The Subway Safety Plan represents, for all intents and purposes, a policing response to addressing New Yorkers experiencing homelessness, mental health challenges and/or economic crises.

[15] MHL§ 9.41 does not differentiate by age of the person who can be subjected to a mental hygiene arrest. A failure to provide essential needs could be used to target homeless and runaway young, always a particularly vulnerable population and now at even more risk of harms in the current political climate.

In New York, homeless and runaway youth are considered to be young people up to the age of 18, and under some circumstances up to the age of 21. NY Executive Law, Article 19-H, § 532-A. According to the MOCMH 2024 Involuntary Transports Annual Report, *supra*, available at https://mentalhealth.cityofnewyork.us/issue-briefs-and-reports (last accessed February 3, 2025), NYC law enforcement forcibly transported at least 535 persons under the age of 18 for psychiatric evaluation in 2024; an additional 795 persons age 18-24 were forcibly transported.

[16] It appears for this reason that Part EE also proposes a new section for Article 9, MHL § 9.04 which would establishing a standard of practice for clinicians who must make determinations of likelihood to result in serious harm.

Importantly, this provision does not apply to mental hygiene arrests effected by law enforcement personnel under MHL § 9.41 as there is no clinical assessment required for law enforcement personnel to take a person into custody and transport them involuntarily to a psychiatric facility for assessment. This provision would apply to clinician directed pick-ups under MHL§ 9.58.

It is also unclear as to why the Governor feels the need to import diagnostic standards of care into a statute. The standards of care may in fact evolve over time and the statute may require amendment. To the extent that the Governor may be trying to ensure a consistent, minimum level of quality healthcare is provided to

all patients and create a legal framework for holding healthcare providers accountable for their actions by defining a clear benchmark for what constitutes acceptable medical practice, proposed MHL§ 9.04 does not accomplish those goals. The proposed addition to Article 9 contains sloppy and conflicting terminologies and appears to suggest that the clinician must apply different standards to different types of diagnostic information, as the subparagraphs toggle between the concepts of "credibility" and "other available relevant information." These terms do not appear in the Mental Hygiene Law. These terms could be broadly interpreted to include any information or opinion that almost anyone offers. If the Governor feels it necessary to enshrine diagnostic standards to this clinical assessment to ensure consistent acceptable medical practice in assessing a person's inability to provide for basic needs, proposed MHL § 9.04 should simply mandate that an assessing healthcare professional carefully examine the available clinical evidence regarding a patient's symptoms and medical history and evaluate the trustworthiness, validity and relevance of any other information gathered about a patient.

[17] NYPD Commissioner Tisch recently announced that the NYPD has just begun using yet another new NYPD academy crisis intervention training curriculum being utilized – that training curriculum has not been made publicly available. *See State of the NYPD 2025, January 30, 2025*, available at https://www.youtube.com/watch?v=ndrbYlzu2yg (last accessed February 3, 2025).

[18] The Mayor's Office of Community Mental Health (MOCMH) has just submitted the *2024 Involuntary Transports Annual Report*, a report required by NYC Local Law 116 (2023), available at https://mentalhealth.cityofnewyork.us/issue-briefs-and-reports (last accessed February 3, 2025). This report is designed to track the City's use of the legal provisions under Sections 9.41 and 9.58 of the New York State Mental Hygiene Law, which allow for the involuntary transport to a hospital for any individual who appears to be mentally ill and is behaving in a manner likely to result in serious harm to themselves or others. We now know, according to the MOCMH report, that NYC law enforcement personnel conducted 7060 mental hygiene arrests in 2024; 661 removals were directed by clinical personnel under MHL § 9.58.

There are, however, significant deficiencies with respect to the data reported here. The numbers for mental hygiene arrests under MHL § 9.41 are likely to be higher as the NYPD data did not capture the first 5 months of 2024, as their tracking started only in June 2024. The MOCMH report also does not capture the outcomes of NYPD-initiated involuntary transport to the hospital, and of course, does not capture what happens following hospital discharge. It is simply impossible to accurately assess whether the city ramped up the use of involuntary hospitalization last year because there is no comparative data for 2023, where the Adams administration has previously claimed that about 130 people per week were involuntarily hospitalized between May and November 2023. Notably, however, in the case of clinician-initiated involuntary transport, discharge without treatment occurred in 42% of the cases. Given the clinical involvement in directed transports of a person for clinical assessment under MHL § 9.58, this discharge rate is quite concerning and demonstrates the difficulty of involuntary treatment prognostication in this area. One can only imagine what occurs when law enforcement are charged with making the mental hygiene arrest determination under MHL § 9.41.

[19] The right of a person to determine his or her course of medical treatment has long been recognized as a fundamental right by the courts in this country. *In Matter of Storer*, 52 N.Y. 2d 363 (1981), the New York Court of Appeals recognized that a patient's right to choose his own medical treatment was superior to the doctor's obligation to provide care, even if the medical treatment was necessary to preserve the patient's life. And, in the seminal New York Court of Appeals' decision in *Rivers v. Katz,* 67 N.Y. 2d 483 (1986), the Court stated that the modern trend in the legal and psychiatric fields is to give even those inpatients suffering from psychological disabilities an increasing amount of control over all of their treatment decisions -- including what medication regimes he or she follows, what therapy sessions he or she attends, and what other mental health programs he or she participates in.

[20] *See Assisted Outpatient Treatment, OMH Data Analytics* dashboard Reports: *Program Statistics: Service Enhancements* and *Recipient Outcomes: Service Participation*, available at https://my.omh.ny.gov/analytics/saw.dll?dashboard&PortalPath=%2Fshared%2FAOTLP%2F_portal%2FAssisted%20Outpatient%20Treatment%20Reports&nquser=BI_Guest&nqpassword=Public123#reports (last accessed February 3, 2025). Note all these mandated services can be viewed on both a regional basis, and, specifically, in New York City on a borough by borough basis. OMH has stopped reporting on mandated participation in individual and/or group therapy, blood or urine testing or day program services.

[21] *See Assisted Outpatient Treatment, OMH Data Analytics* dashboard, *Reports: Program Statistics: Petitions Filed*, available at https://my.omh.ny.gov/analytics/saw.dll?dashboard&PortalPath=%2Fshared%2FAOTLP%2F_portal%2FAssisted%20Outpatient%20Treatment%20Reports&nquser=BI_Guest&nqpassword=Public123#reports (last accessed February 3, 2025).

[22] The NYCLU is lead class counsel, and continues to monitor a consent judgment, in the Willowbrook class action litigation that was filed 50 years ago in the United States District Court for the Eastern District of New York. *New York State Assoc. for Retarded Children v. Cuomo*, Nos. 72 Civ. 356/7 (E.D.N.Y., Hon. Raymond J. Dearie) ("Willowbrook"). The NYCLU, with others, commenced the Willowbrook lawsuit in 1972 to correct the inhumane institutional conditions suffered by the residents of the infamous Willowbrook State School. We successfully argued that the United States Constitution guaranteed such individuals the right to due process in the decision to institutionalize them; freedom from abuse and unreasonable restraint within the institution; a clean, sanitary environment; nutritious food; adequate clothing; decent medical care; protection from harm; and appropriate treatment or habilitation to improve their mental condition or to increase their skills.

[23] Shifting service delivery systems into long term managed care to effect cost savings harms both the people who depend on services, as well as the direct support providers, or staff, who provide those services. The commentary, and testimony before this Legislative body, has been extensive over the years. As but a few examples, s*ee e.g., Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans*, Medicaid Matters New York and New York Chapter National Academy of Elder Law Attorneys, Inc., July 2016, available at https://ilny.us/phocadownload/Report-on-Medicaid-Home-Care-Reductions-in-New.pdf (last accessed February 3, 2025); *Wage Parity for Home Care Aides*, PHI Medicaid Redesign Watch, available at https://www.phinational.org/wp-content/uploads/legacy/research-report/medicaid-redesign-watch-1.pdf (last accessed February 3, 2025).

[24] As OPWDD and DOH are aware, Deloitte has long been intimately involved with New York State health actuarial services consulting.

[25] *See, e.g.*, IDD LTSS Carve-In Cost-Effectiveness Evaluation – Final Report Prepared for: Texas – Health and Human Services Commission (HHSC) HHSC Contract No. 529-15-0009-00001 | Request Number: 00021-R3
Version Dated: January 11, 2019, available at https://hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/idd-srac/feb-2019-idd-srac-agenda-item-2.pdf, at pg. 16 (last accessed February 3, 2025).

The Medicaid and Chip Payment and Access Commission ("MACPAC"), a non-partisan group of experts, convened pursuant to the Social Security Act (42 USC §1396), also concluded in 2021: "While much research has been conducted on whether Managed Care delivery systems result in better outcomes than fee for service (FFS), there is no definitive conclusion as to whether managed care improves or worsens access to or quality of care for beneficiaries." *See Managed Care's Effect on Outcomes,* MACPAC, available at www.macpac.gov/subtopic/managed-cares-effect-onoutcomes(last accessed February 3, 2025).

[26] The NYCLU is a member of a coalition of mental health service providers, disability justice, housing rights and criminal reform advocates, other civil rights advocates, and people with lived mental health experience who share your concerns about vulnerable people falling through the cracks of our failed mental healthcare system and being left unable to access stabilizing resources like housing and community-based care. We are all strongly opposed to the Governor's focus on expanding involuntary inpatient and outpatient treatment, which are ineffective interventions to address these structural issues. The coalition requests that the Legislature invest in solutions that work, including housing, services, and care, as we detailed here in our testimony.

[27] *See* Judge David L. Bazelon Center for Mental Health Law, *Mayor Adams' Plan Will Not Help New Yorkers With Mental Disabilities*, December 22, 2022, *supra*. *See also* Center for Court Innovation, *The Myth of Legal Leverage?* ("Studies of therapeutic intervention strongly suggest that the quality of the human interaction outweighs the importance of any particular protocol or approach…." "factors like goal consensus, empathy, alliance, and positive regard are significantly greater than, say, model fidelity," and "a robust therapeutic relationship is less a matter of dosage and more a matter of engagement."), *supra*.

[28] *See* Forum Staff, *City Launches Homeless Advocacy Project*, The Forum (Jul. 21, 2022), available at http://theforumnewsgroup.com/2022/07/21/city-launches-homeless-advocacy-project/ (last accessed February 3, 2025).

[29] S. Tsemberis & R.F. Eisenberg, *Pathways to Housing: Supported Housing for Street-dwelling Homeless Individuals with Psychiatric Disabilities,* Psychiatric Services Vol. 51, Issue 4, 487-93 (2000), available at https://doi.org/10.1176/appi.ps.51.4.487(last accessed February 3, 2025).

[30] Bazelon Center for Mental Health Law, *Diversion to What? Evidence-Based Mental Health Services that Prevent Needless Incarceration* (September 2019), available at http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf (last accessed February 3, 2025).

[31] *See* Coalition for the Homeless, *State of the Homeless 2024: Rights Under Attack, Leadership in Retreat*, available at https://www.coalitionforthehomeless.org/state-of-the-homeless-2024/ (last accessed February 3, 2025). The report by the Coalition for the Homeless, the plaintiff in the *Callahan* case establishing the right to shelter in New York City, offers a robust menu of housing types that are necessary to meet the needs of unhoused New Yorkers.

[32] United States Interagency Council on Homelessness, *All In: The Federal Strategic Plan to Prevent and End Homelessness* (December 2022), available at https://www.usich.gov/All_In_The_Federal_Strategic_Plan_to_Prevent_and_End_Homelessness.pdf (last accessed February 3, 2025).

[33] *Id*. at 20.

[34] *Id*. at 20.

[35] Donna L. Hoyert, Ph.D., Maternal Mortality Rates in the United States, 2020, Division of Vital Statistics, Centers for Disease Control and Prevention, available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm. (last accessed February 3, 2025).

[36] New York State Report on Pregnancy Associated Deaths in 2018, N.Y. Dept. of Health, p.1, available at https://www.health.ny.gov/community/adults/women/docs/maternal_mortality_review_2018.pdf (last

accessed February 3, 2025) citing New York State Vital Statistics Tables (https://www.health.ny.gov/statistics/vital_statistics/vs_reports_tables_list.htm). (last accessed February 3, 2025).

[37] The *MHANYS Ten Point Comprehensive Action Plan to Improve New York's Mental Hygiene System and Crisis Response* is available at https://mhanys.org/mh_update/mhanys-ten-point-comprehensive-action-plan-to-improve-new-yorks-mental-hygiene-system-and-crisis-response/ (last accessed February 3, 2025).