New York State Attorney General

Public Hearing On Access To Mental Health Care In Western New York

January 18, 2023

AG LETITIA JAMES: Good morning, everyone.

WOMAN: Is this on? Hello.

AG LETITIA JAMES: If you don't know --

WOMAN: Everybody take their seats, please.

AG LETITIA JAMES: -- my name is Letitia James --

WOMAN: We're about to begin.

AG LETITIA JAMES: -- and I want to welcome all of you --

WOMAN: It is now 11:01 and I (indiscernible).

AG LETITIA JAMES: -- to this hearing. March will mark three years --

WOMAN: Good morning, everyone. Cameras, heads up.

AG LETITIA JAMES: So --

WOMAN: Hello.

AG LETITIA JAMES: -- if you don't know, my name is Letitia James --

WOMAN: Everybody take their seats please. We're about to begin.

AG LETITIA JAMES: -- and I want to welcome all of you --

WOMAN: It is now 11:01 (indiscernible).

AG LETITIA JAMES: -- to this hearing. March will mark three years --

(sound overlap)

AG LETITIA JAMES: -- that are battling anxiety, or stress, or depression brought on by grief, fear, or helplessness, or pre-existing serious mental illness exasperated by overburdened system challenged to provide necessary critical care. This is not -- they're battling anxiety, or stress, or depression. And without real tangible action and intentional change, this mental health crisis will continue. And one of the greatest obstacles we face is an unrelenting decline in the number of inpatient psychiatric beds available for our most vulnerable.

And as we struggle to provide accessible long-term services for those who need them most, demand continues to increase. In the governor's State of the State Address last week, the governor announced a proposal to deliver the beds and care capacity that we so desperately need, and that proposal is promising. It is

encouraging, and I support the governor in her effort. But still there is much to be done for it to be successfully realized.

In response to the pandemic, more than 1,000 patient psychiatric care beds were eliminated or converted to COVID-19 care. As late as November 2022, the (no sound) hospital in Niagara County closed its inpatient psychiatric unit in November of 2019. That's three hospitals. Soldiers and Sailors Memorial, Brooks TLC, and Easton Niagara Hospital.

We also know that Medicaid doesn't provide coverage for long-term stays for mental health care and hospitals with fewer than 16 beds for the vast majority of patients. And while there is federal legislation pending, people unfortunately are still hurting. And other hospitals are forced to deal with an unsustainable demand for beds and services.

Erie County Medical Center's Comprehensive Psychiatric Emergency Program is the busiest program of its kind in New York. This hospital has absorbed many patients coming from Niagara County where there are very few services, and patients are almost always waiting

in the hospital's emergency department for an inpatient psychiatric bed.

In recent years, brave and determined nurses confronted administrators at ECMC about the facility's staffing plans. They are understaffed and overcrowded putting both patients and nurses in harm's way. We've been told stories of children left behind at the emergency department for behavioral or mental health disturbances. They are left behind to live in hospitals because community based alternatives and services are inadequate and understaffed.

Advocates tell us children in foster care are unable to get referrals to residential treatment facilities because they have no where permanent to go afterward. And we know where some of them end up. Some of them end up with run-in -- with run-ins with their -- with the police, which only limits their options. With low capacity at detention facilities, police report they have no where to take them but to programs like the one at Erie County Medical Center.

And though we are beginning to put the

pieces back together, it will take years, years to reverse the impacts of the lack of accessible long-term psychiatric care on our communities and in this community. And in the absence of that care, we have seen an increased over-dependence on hospital emergency departments and frantic calls to 911.

Care for serious mental illness does not happen overnight. It cannot be solved by one visit from emergency medical personnel. Without services and long-term support, the same people are ending up in the same situations over and over again. And oftentimes we find them in our correctional facility, the subject of another 911, back in the emergency department, parents desperately trying to find answers to help their loved one.

They end up on our streets unhoused in overrun shelters lost to the system that failed them with little hope of accessing the medication or services that they need. No care. Endless consequences. The devastation, the harm, the loss. I know that it's crushing.

A pastor, Pastor Robinson of Spirit of Truth Urban Ministry in East Buffalo welcomed

more than 100 of her neighbors to take refuge in her church during this most recent violent storm that claimed dozens of lives. She summed up how too many are feeling. We haven't really got a chance to heal. When are we going to have a moment to just breathe? And that's why we're here today. To find the space to heal and to help build the room to breathe, and not to be judgmental, but to let individuals bear their souls and to talk about the challenges in the mental health system.

This hearing is not limited to any one population or any single patient. We are examining the entire system from Buffalo to Brooklyn because each region of our great state is navigating its own unique challenges in its own unique landscape. In June, we held our first mental health hearing in New York City. We heard from our downstate neighbors, and today we are hearing about the compounding crisis facing western New Yorkers.

We'll hear from elected officials advocacy organizations, healthcare providers, and government agencies. But more importantly, we will hear from members of the public and

specifically family members, your family, your friends, and your neighbors who will tell us about their encounters with the mental healthcare delivery system in the state of New York. We've already received dozens of written testimony from western New Yorkers, and several have joined us here today, and I really want to thank you.

I want to take this time to thank each and every one of you for coming out here today. Whether you are here with us in person, sharing testimony in writing, or turning in on our livestream, we thank you. Your experience, your input, and your time are all critical to our efforts. And throughout this hearing, we'll give those who live with and through the challenges of mental illness the space that they deserve to be seen and to be heard.

We are seeking to root out areas of dysfunction and discuss potential avenues for reform and then bring it to the appropriate individuals, or in the case of our office, pursue it legally. My office will review everything that is said here today along with the hundreds of written submissions that we have received. If you have not shared with us and have a story to

tell, we still want to hear from you. You have until this Friday to submit your testimony. That's Friday, January 20th.

We welcome and encourage you to submit your testimony online at ag.ny.gov/governmental-health-hearing. Again, ag.ny.gov/mental-health-hearing.

Before we begin, I'd like to take a moment to thank the tremendous staff here at the Buffalo and Erie County Public Library for welcoming us. I love libraries. I used to -- yes.

(applause)

AG LETITIA JAMES: I don't know if all of you are old enough to remember the stacks that they had in public libraries. I used to hide away in the stacks, and I introduced myself to so many books, and we love libraries.

I also want to introduce the individuals who are on the dais with me. To my far left is Gina Bull. She's an Assistant Attorney General and Special Assistant to the First Deputy Attorney General. Gina's been with me for a very long time.

Jennifer Levy is to my immediate left.

She is my First Deputy Attorney General, someone who's been with me for a very long time.

To my immediate right is Michael Reisman who is a genius as they say, someone who's well-steeped in the -- in healthcare. And he's an Assistant Attorney General in the Healthcare Bureau of the Office of the Attorney General. And they will be here throughout the hearing to ask questions and retain critical information that will aid in our follow-up actions in the weeks and months to come.

And of course all the way to my far right is our parliamentarian, who I will turn it over to now. She's the Assistant Attorney General Stephanie Calhoun who will go over the rules and process for today's hearing and introduce panels of witnesses. And she will lead us forward.

Stephanie, you have the floor.

AAG STEPHANIE CALHOUN: Thank you very much, AG James. Good morning and welcome, everyone. I'm Stephanie Calhoun. I'm an Assistant Attorney General in the Buffalo Regional Office, and I will be today's parliamentarian for today's hearing.

In this role, I am responsible for the timing and the flow of the proceedings, and I will provide a brief overview of how that will happen. Each individual making a statement or testifying will have an allotted time to speak today. There is a clock that will count down both to the panel and to the individual speaker so that they can monitor their own time.

I will give a 30-second warning by showing a piece of pink paper so that the speaker will know to conclude their testimony. And after each speaker is done, there will be time for questions and answers, if any, both individually and in small groups.

Now I would like to introduce our first speaker County Executive Mark Poloncarz.

MARK POLONCARZ: Thank you, Madam Parliamentarian, and thank you to all that are gathered here today, especially Attorney General Letitia James and her team for joining us to talk about this very important topic of mental health services for all. And I'd like to thank you for choosing the Buffalo and Erie County Library owned by the people of Erie County.

Unfortunately, there is a mental health

crisis in America from addressing the opiate and addiction epidemic to the lack of appropriate housing for those suffering from a mental health problem, to the mental health issue facing our children in a post-COVID-19 environment. Our nation is facing a mental health crisis unlike any other.

Due to our role as a key partner in the provision of health and mental health services to our community, Erie County has been an active partner in addressing all of these issues. As county executive, I've made it a priority of our administration to increase access to mental health services for all throughout my tenure.

Between the COVID-19 pandemic, the May 14th mass shooting, and most recently the Christmas blizzard of last month, the need to access mental health services for all has never been more important. I would like to use my brief time to share what steps we have recently undertaken to help our residents in case others in attendance are not aware of these programs, and also would like to speak in favor of a number of initiatives that have been -- recently been announced.

First, Erie County's newest initiative is called Erie County SMART Collaborative. SMART Supporting Mental Health by Advocating for Resources Together, is an initiative that brings together preschool through 12th grade educators, community agencies, and Erie County representatives to collaborate on available mental health and social emotional learning tools within our community.

The goal of Erie County SMART is to ensure our students and their families are connected to the many mental health services that are available. For example, as part of SMART to be launched later this year, families will be able to use a SMART phone app that will allow parents to access mental health services specifically for their children's needs.

This regionwide approach will provide the opportunities, identify emerging needs, and build the capacity to meet the needs of children, which as we know are completely different than those of adults. I want to thank all the partners involved, including Erie 1 and Erie 2 BOCES as well as all the school districts who believe that this will help our children.

Next, our Erie County Office of Health Equity would begin offering mental health first aid training for 2,000 members of our community in the coming weeks. This first aid training is to help peers, teachers, coworkers, supervisors, or anyone else in our community to have the knowledge in how to recognize and respond to signals and symptoms of mental health or substance abuse challenge in adults and youth.

We know often that the first steps can be identified if individuals know what to look for, and that is why we will be training those individuals so that they can identify early on a mental health need.

We know there are no silver bullets in the public policy of this area, but we understand that there are certain actions that can be taken and should be taken to address this. That's why I do support a number of the initiatives that were announced by Governor Kathy Hochul in her recent State of the State.

I wholeheartedly endorse the governor's call to increase the operational capacity by 1,000 beds for inpatient psychiatric treatment that will create also 3,500 units of housing to

serve New Yorkers with mental health illness. Our mental health department also supports this call and believes it will help alleviate the issues faced by the Erie County Medical Center's Comprehensive Psychiatric Emergency Program, otherwise known as CPEP, a significant concern in our community.

I also support Governor Hochul's call to increase insurance coverage for mental health services, expand outpatient mental health services, and better account for hospital admissions and discharges to address the needs that are suffering from a mental health illness.

Unfortunately, with the deinstitutionalization of a lot of individuals, hospitals and prisons are now their homes. We need to find a place for them that can care for them every day of the year.

(applause)

MARK POLONCARZ: These are just a few of the necessary steps that will begin to address the crisis in Erie County as well as across New York state. I ask all New York state partners in government to support these initiatives to build a stronger, better, and healthy Erie County for

all. And I thank you, Attorney General James, for bringing forth this very important subject and giving us an opportunity to discuss it and hopefully create a better community for all. Thank you.

AAG STEPHANIE CALHOUN: Thank you, County Executive.

(applause)

AAG STEPHANIE CALHOUN: And let's give a round of applause to the County Executive on his response to the recent snow storm. He did an amazing job. So thank you.

(applause)

MARK POLONCARZ: Thank you. We have a great team.

AAG STEPHANIE CALHOUN: Yes, you do. I don't really have any questions. Anyone have -- on the panel have a question?

AAG MICHAEL REISMAN: I just have a quick question, sir, and it relates to the snow storm. Obviously, there was a tremendous crisis --

MARK POLONCARZ: Mm-hmm.

AAG MICHAEL REISMAN: -- in this region and it received international media coverage for

the crisis itself, as well as for the response. Are there aspects of the County's response that could be utilized, maybe they already are being utilized, in forward thinking in terms of responding to the mental health crisis?

MARK POLONCARZ: Well, through our Department of Mental Health, we are sort of the overseeing agency for all the subagencies, the not-for-profits who often receive financial aid through Erie County that is also passed down from New York State. So we have a good relationship with all of those entities to ensure that they have the necessary means at their disposal so that they can get through a storm.

One of the things that we learned, especially with the creation of our 858 snow number is a number to help citizens in need for what would be considered a non-911 crisis is that it started to become the phone call that was used by the community when they couldn't get through the 911 when it was too busy, or services couldn't be provided.

We have a list of individuals that of course called their phone numbers and addresses if they provided it who were going through

serious situations there, some who thought they were going to die in their vehicle, others who thought they may die at home due to lack of having electricity and heat. So for us, we want to ensure that those individuals not only go through that initial crisis situation, but that they also are able to move on from it.

Our community has taken hit after hit after hit. The end of the COVID -- well, we really don't have the end of the COVID-19 --

AAG MICHAEL REISMAN: Right.

MARK POLONCARZ: -- crisis. It's just slowed down. To of course the shooting on May 14th to a terrible snow storm in November that took lives to the blizzard to five children who died in a horrific fire on New Year's Eve. And then of course the -- I didn't include it in my testimony, but the mental health crisis that was in some ways created by the Damar Hamlin incident --

AAG STEPHANIE CALHOUN: Yeah.

MARK POLONCARZ: -- and the effect it had on individuals who are not used to it. So our goal is to ensure that the resources are available. We know there are plenty of resources

in our community. The difficulty is also often matching them to the specific need of an individual. That's why we created Erie County SMART to help parents find out what is available to help their children in a situation such as that, and any individual who's dealing with a crisis situation, or just wants to talk to a counselor.

We have the ability to match them. They just have to contact us. And as we all know, sometimes communication is the most difficult part, getting that information out so that people can take advantage of the services that do exist.

AG LETITIA JAMES: And County Executive, in the next state budget, will there be additional resources for community based organizations to make up for the loss of beds?

MARK POLONCARZ: I hope so.

AG LETITIA JAMES: Okay.

MARK POLONCARZ: There's a significant need for it in this community. As is known in this community, there is an issue associated with the Erie County Medical Center's CPEP program.

AG LETITIA JAMES: Yeah.

MARK POLONCARZ: It is often because they cannot release individuals who need to be released because there's no place for them to go in the community. They can't just be released on their own. And it is a concern. Our Department of Mental Health has been watching it for some time, discussing it with CPEP, discussing it with the Office of Mental Health for New York State knowing that you cannot just place individuals in hospitals and have them stay there permanently, which unfortunately is what's happening in some situations with CPEP.

It happened a lot with regards to COVID-19 in which individuals who came in with COVID-19 and were sick but could not be moved back out in the community because there were no beds available for them.

AG LETITIA JAMES: Right.

MARK POLONCARZ: So they became almost permanent residents of Erie County Medical Center Corporation, and that is an unsustainable model. So we need to have more beds available, and I do hope it is included in the upcoming state budget.

AG LETITIA JAMES: Thank you, County Executive. Thank you for your testimony. I

appreciate you. Thank you so much.

MARK POLONCARZ: Have a good day.

(no sound)

AAG STEPHANIE CALHOUN: -- the next testimony, which will be held virtually by Senator Samra Brouk, Mental --

(no sound)

SENATOR SAMRA BROUK: -- week we heard a proposed $1 billion investment in New York's mental healthcare system. And as wonderful as that sounds, we must stay laser-focused on what we know will improve our systems, not in the distant future, but today.

Before we consider any changes to our mental healthcare system, we must first address the underlying staffing challenges we face here in New York. Right now, families in need of care are waiting up to nine months to see a provider. We must invest in a well-trained, well-compensated workforce.

And as we look to strengthen our workforce, we must also ensure that we have the right professionals to respond to mental health emergencies. Too often situations needlessly escalate often causing further harm to those in

crisis simply because our emergency system was not built with their needs in mind.

I sponsored Daniel's Law, named for Daniel Prude, who was killed following a law enforcement response to his mental health emergency. This legislation would ensure that qualified mental health providers are first to respond to those moments of crisis rather than law enforcement, and that we meet those in crisis with compassionate care and never brute force.

Finally, we must recognize that mental healthcare must begin earlier in an individual's life. That means not only offering more services to young people, but considering more support services for burdened parents as they bring their children into this world. Providing services such as doula care is a proven step to improving maternal mental health outcomes, and thus setting a stronger, more stable foundation for our children and families.

In 2023, we find ourselves unfortunately in the crisis after the crisis, the epidemic following the pandemic. We must respond swiftly and intentionally to this crisis by investing in mental healthcare, and ensuring that

our system is accountable to the needs of New Yorkers.

Again, quickly, I do want to thank our Attorney General for the opportunity to speak and for coming to us through New York to ensure our voices are heard when it comes to her role in addressing the mental health crisis. Thank you.

AAG STEPHANIE CALHOUN: Thank you. Senator, can you hear us?

SENATOR SAMRA BROUK: I can hear you.

AAG STEPHANIE CALHOUN: Okay. I understand there was a rally this morning in support of that, the Daniel Prude legislation. What's the likelihood that it's going to pass in this legislative session? Senator?

SENATOR SAMRA BROUK: Yes. I can hear you again.

AG LETITIA JAMES: Did you hear the question?

SENATOR SAMRA BROUK: I heard -- I lost you.

AG LETITIA JAMES: Oh, okay. So there was a rally, I understand, in support of that legislation, the Daniel Prude legislation, this morning from what I understand. What's the

likelihood that it's going to pass in the session?

SENATOR SAMRA BROUK: Well, I'm hopeful that we will strongly consider it this session. I think honestly one of the most incredible things about this legislation is that it's bipartisan, and I think there are very few things in this day and age that we can say folks on any side of the aisle support. And so that's something that's really, really encouraging to me.

I think we've seen that there are everyone from the top executive of New York down to, you know, some of our local precincts here in New York state that folks realize the system we've created is not meant to help people in a mental health crisis. And so we've enjoyed support from a statewide coalition, including Daniel Prude's family, on this measure. And I'm hoping that we can actually move it forward this year.

Again, when we look at that, you know, billion dollar investment that was promised in the State of the State, some of that funding goes to some of these mental health emergency system

changes. And this is the reform I think will make the biggest impact for all of New York.

AG LETITIA JAMES: And you indicated you support the $1 billion initiative proposed by the governor in her State of the State Address. Do you suspect that there'll be an increase in that $1 billion initiative?

SENATOR SAMRA BROUK: You know, I think it's $1 billion over five years. So certainly it's a huge step forward. We've got an executive who understands the nature of the crisis. But one thing I have to add is that all of this will be for naught if we don't do what we need to do to invest in the workforce.

And so while I support increased investment, the truth is that's not going to solve the crisis we're in. And what we really need to do is also consider how we're going to take care of those who take care of us and our families by retaining and recruiting even more mental health providers. Because all of those programs that were lined up, all the programs we hope to bring online to better serve New Yorkers are only possible if we've got the caring human beings who are licensed and ready to do the work.

And so there's a lot we need to do with the workforce as well.

AG LETITIA JAMES: And do you also support the fact that -- making sure that beds that were converted to COVID beds during the pandemic are returned to the psychiatric units?

SENATOR SAMRA BROUK: We absolutely need to bring those beds back online. We absolutely -- I think I heard the tail end of previous testimony that we simply don't have anyplace to place folks who even come voluntarily to get the care that they need. And they are assessed, and they have a treatment plan, and they need a bed to take that treatment on. And we don't have them right now.

So absolutely in support of bringing those beds online, and really considering what we can all do to make sure that we're holding folks accountable for bringing those beds back online.

AG LETITIA JAMES: Members on the dais have any questions?

AAG MICHAEL REISMAN: Senator, just a quick question. How will the proposed legislation ensure appropriate crisis response in both urban and rural areas around the state?

SENATOR SAMRA BROUK: That's a fantastic question and one that I obviously took seriously when introducing this bill in my first term and continuing to do so in this term. Because I represent urban, suburban, and rural areas, right? And I have a very diverse constituency that is going to need that care.

One of the things that we really took into account when it comes to Daniel's Law is the idea of regional input and making sure that a crisis response structure may look different. And I'll just name Bloomfield for any western New Yorkers who might Ontario County in my neck of the woods.

It might look very different there than it does in the city of Rochester. So that is part of what we've been doing in the last two years of really making sure we have a full statewide coalition that, yes, did it start in the city of Rochester? Because that's unfortunately where Daniel Prude lost his life. Yes, but we've been intentional in making sure that those voices are included as we iterate and make sure that this is truly legislation that best serves folks from all over the state.

AG LETITIA JAMES: Thank you, Senator. Thank you for your testimony. I appreciate it.

SENATOR SAMRA BROUK: Thank you so much.

AAG STEPHANIE CALHOUN: We will now have our next panel who are individuals with family members or lived experiences. I would like to introduce the panel. Elisa and Joe Tobia, Brendan Orr, Tylica Pope. I ask that we start with Ms. Pope. Please be mindful of the time. And you may hear a beep, and that will signify the end, and I'll alert you when you get close.

TYLICA POPE: Thank you. Can you hear me?

AAG STEPHANIE CALHOUN: Mm-hmm.

TYLICA POPE: Okay. I thought it was going to go the other way, but thank you for allowing me to start. Again, as they spoke, I am Tylica Pope. Most people call me Ty. It may not look like it, but I am someone with lived experience. I have had the opportunity to be able to help to navigate through the mental health system.

As a youth and now in my current

position as the vice president of Specialty Substance Use Disorders and housing, I also have the privilege to be able to work with individuals who have mental health and just also looking to navigate through the system. From my experience with mental illness, I have lived with mental illness for many years and tried to access services very -- at a very young age, which had been very difficult.

When you are desperate, you feel alone, you feel isolated, you feel alienated because there's only one door for you. At the time, it was one door for you to go in to get services. You had to go to the emergency room to access those services. And sometimes I know for me that wasn't always the best avenue for services trying to go receive services in what seemed to a retrofitted treatment or process for individuals.

Thank you. Okay. Sorry about that. There are multiple barriers that I had dealt with, and I also identified opportunities to support to include the system. I depended on services to provide and obtain my recovery and treatment. You know, being diagnosed with mental illness, again through desperation, having those

-- looking for answers to be able to assess with the care that I needed.

And also being a woman of color, in a black community where mental health was frowned upon for seeking treatment. People didn't understand me, your family didn't understand you, community didn't understand you. And so having to go to a system to where you only can access services through this one door was not always beneficial.

Now being a service provider and understanding that we need to have multiple pathways of recovery for individuals, you know, the Certified Community Behavioral Health initiatives weren't very helpful because you're able to offer individuals with multiple pathways. They can see multiple service providers in one day.

They have peer services where individuals are able to access services and care for people that don't understand it and they don't know what to expect. So that was very -- you know, it helps break down the barrier of mental illness where it's more inclusive and collaborative, less shaming because there's

choice -- there's a choice there.

Helping to bridge the gap for services and relate -- help people to relate and connect to individuals that they can understand, which is very important, you know, understanding that, you know, the workforce -- right now we have a workforce crisis, and we don't have enough funding to be able to have individuals work to provide this care.

And so it's very important that I know we have new initiatives coming on board. However, we also need to be able to sustain what's available right now because that's been working. And so putting our finances to be able to maintain those services as well as other innovative initiatives to be able to allow people the support they need for care.

We also want to -- I want to talk about the, you know, crisis stabilization centers. That's also very hopeful because those will offer peer supports. I started my work as a peer. And if you think about it, if you have people being able to access services that they can relate to and that's necessary for them, they'll be able to be just like me one day, vice president. One day

a counselor, one day an attorney general, who knows? The possibilities are endless when we make sure that we have a service structure that's able to support people in their recovery.

And so I'm here to talk about not only having -- being a woman of experience with mental illness, I'm also talking about -- I'm also standing here as a living product of how that services can work and change your life. Very transformative, but we also have to make sure that the funding lines up with the support that, excuse me, that we're offering individuals.

AG LETITIA JAMES: Thank you.

(applause)

TYLICA POPE: Thank you.

ELISA TOBIA: Hello. My name is Elisa Tobia. I'm from Corning, New York, and my husband Joe is with my son's photo Matthew Tobia. Corning, New York, first of all before I talk about Matthew, Corning is in Steuben County. If you look up the geography of Steuben County, it's probably almost as big as Rhode Island with a population of about 95,000 people, okay? Rhode Island has I think 1.1 million people, so that's a factor. Population, funding.

But to start at my script to stay within my minutes, it's my honor here today to present this testimony, and I understand that it's the first reform look since 1970s. I'm a family consumer sciences educator, and I'm confident in the processes that are employed by the Attorney General's Office to identify the common threads, the benefits within the system to aid all of us affected by mental illness.

My wish, though, would've been that Matthew my son would be here to express his experience firsthand. He died by suicide in August of 2021. Feels like yesterday, so I pause on the date. He and I did a lot of consumer advocacy during his lifetime. In his absence, though, I will share this.

Matthew was a stellar high school athlete on a lacrosse scholarship to play a division one University of Delaware where he suffered a career-ending injury during the time with the opiates were handed out by doctors under advisement by pharmaceutical industry. You know, the candy stuff.

Well, it took him four years, but he is a testament to being able to beat opiate

addictions. Subsequently, though, his brain was altered, and he suffered a severe mental illness in the form of schizoaffective disorder. In his lifetime, he had a varying quality of healthcare policies, which I can provide to you so you can track what do you get when you're on Anthem or Medicaid or straight Medicaid. But I won't do that because we only have a couple of minutes.

So it's a huge player, and it's -- health insurance drives what happens in all of medicine. We know that. Particularly as it relates in mental health. It's all profit over people. It's the same with pharmaceutical. Profit over people.

We can produce records where injectables have been used. I'm a numbing finger, legs (indiscernible) person. You know when you find out you get an injectable and three days later your schizophrenia qualifies you by insurance standards to discharge there are a few issues.

We also have issues where the discharge is so frequent and the interpretations are different. In his last hospitalization at Olean General Hospital 90 days before he passed away,

the record indicates -- I'm doing a root cause analysis, so that's how I know these things. I have all of his medical records from birth to autopsy. I've offered them to Ann Sullivan at her public forum, and I've offered it and been able to provide it to you here in the last year.

But his statement in that was that he was going to kill himself and that he knew why. But he was deemed a low risk in the facility, but a high risk to return to their facility. Staff later explained to me after I notified them, because there is a slight disconnect. You know, you don't ever know what happened to your patient.

So but they -- as a courtesy, they did take my call, and I explained to them that he died by suicide a few months later. And they explained the limits of the safety net coverage that he was on. I don't know. I guess, you know, sick doesn't tell you. Insurance tells you. So the results of this analysis are really quite nauseating.

And my son would often say to me why don't they want to help me. But my husband and I are true educator systems people. We like to

think systems work, so we always redirected him to his caregivers. Right? You're sick. Go back. Go back. They know what they're doing. Well, what he was redirected to after my studying here, and a lot of work OMH. I have to compliment them. Okay. They're really trying very hard, but they have nothing to -- they -- you know, great ideas, want to do things, you know?

Then Medicaid says, oh, the price of stabilization, they're allowed to say 23 hours and 59 minutes, okay? That's what's on statute right now for the plan. So we'll see how well somebody in Steuben County's going to do driving 100 miles to get to Elmira, New York from the far reaches of Steuben County to stay there for 23 hours and 59 minutes to be stabilized and given a place to go.

Doesn't sound like it's going to work to me. But there are a plethora of programs, ideas, ONH, Oasis, the New York State Department of Health that he should've had opportunities for. But nowhere in the record, man, nowhere in the record was he offered more than one time per month counseling and 10-minute Medicaid-allowed

medication management appointments with a psychiatrist. Ten minutes.

AG LETITIA JAMES: Ten minutes?

ELISA TOBIA: Ten minutes. Sometimes by phone. You're lucky if you get Zoom, you know, because you can see. Words don't match behavior, facial behaviors. But that's what he got. I learned through OMH everything they're trying to give, but in Steuben County, ma'am, that's all he got.

So far I'm still digging. I'm digging. So as I embark on this study, as there really isn't a root cause analysis outside of licensed facilities. So if you have a person die by suicide in a licensed facility, it will go to the justice center and the joint commission. They will turn over every email, every action of anybody under the sun.

However, when you're an outpatient and outside of the bricks and mortar, there's an internal incident review conducted in each entity. So I've done it. My goal is that you will have a law on the books that says if somebody dies by suicide in an outpatient setting, and they're engaged in treatment, that

we do a systemic review. Not to punish anyone --

AG LETITIA JAMES: Right.

ELISA TOBIA: -- but to make corrections and improvements to the system. I've had the opportunity to talk to Lanny Berman, who is Johns Hopkins University, also had been the adjunct -- our suicidology folks, and they have a law now on the book in Maryland for a suicide fatality review board at the state level. And I encourage looking into that.

So we're all in it together. My son's response level when he was in a crisis, ma'am, was the police department, and they were wonderful. The healthcare people who were trying to do the job were wonderful. It is a system problem, a financial problem. Again, time is running out. So we're all in it together, and we're all falling apart together. And we're losing the people, and all of the people.

So in his greatest time of need, I am most thankful to Corning Police Department. Because when you call their on-call number for the County Mental Health, it's a switchboard for 50 bucks a month through Guthrie Healthcare System to go to the county person who then says,

well, we'll call the person back. It'll come in from an unknown number. Or we don't have enough time because we're in Cornell, New York 45 minutes away from you. Call the police.

Why call the County anymore? We just called Corning Police Department and they developed a relationship with my son, and I'm forever thankful to that. I will stop. I could go on and on. You all know that because I do, so I will stop.

(applause)

AAG STEPHANIE CALHOUN: Just a reminder to speak as close as you can to the microphone. Thank you, Mr. Orr.

BRENDAN ORR: You got it. Thank you. I timed myself. I might go a minute over, but I promise I'll be respectful of everyone's time. Good morning, Attorney General James and all of those joining us today. To describe the current state of mental health issues facing communities in the city, state, and country as a crisis would be a massive understatement.

Buffalo's metro area encompasses more than one million people, yet the resources available to those who are struggling is abysmal

at best. I know this firsthand as I'm here to share the story of my sister Jennifer Orr who took her own life just two months ago on November 15, 2022, and was failed by the very systems that are supposed to aid those who are struggling.

Jennifer was 33 years old when she passed away. She was brilliant and lit up every room she entered into with a big smile and one of her famous hugs. Jen could enter into a room filled with a bunch of people she had never met and walk out with as many new best friends. She was the most passionate person I have ever known when it came to the causes and the people that she cared about.

She was active in the arts and music communities, in the political and advocacy communities, and countless other communities, and gave everything she could to make those spaces a better place for those who occupied them. I looked up to Jen growing up more than pretty much anyone else, and for the majority of our lives we were the best of friends.

While on the outside, we all saw Jen as this incredible, unstoppable beacon of light, she was deeply struggling on the inside and only

allowed those closest to her to know of her battle. Jen found herself at the intersection of some deep mental health and addiction issues, and struggled with this for nearly 20 years. She was diagnosed as bipolar, and my parents tried many times throughout her adolescence and early adulthood to get Jen help, but it was to no avail.

The past few years have been particularly hard on our family due to a variety of things that have occurred, which only made Jen's mental health and alcoholism struggles even worse. Even when we'd be out doing stuff, family stuff, with my dad, my other sister Megan and Jen's partner Jake, you could see the pain in her eyes and behind her smile.

Jennifer had an incident with a knife back in September, which resulted in my father and I in the aftermath having an intervention with her. I'd researched services available to support us and through Erie County's website came across Erie County's Emergency Mental Health Response Team, which I believe is Crisis Services.

I called the number on the County's

website, and after a couple of transfers finally reached the folks we needed to. The person who I spoke with said that Jen's circumstances sounded as though they warranted her getting admitted. We knew that she wasn't going to be happy about it admittedly, but even if she wouldn't accept the help from us initially, all the people closest to her knew that this was a life or death matter and that she desperately needed help. And I will go onto explain why.

We had concrete proof that Jen was feeling this way, and felt so low that she wanted to take her own life. We have text messages from her saying that she wanted to kill herself in September. Myself and her partner Jake heard her say it out loud multiple times. And to top it all off, we had an act of her almost doing it, as I had mentioned, with the stitches on her face and the medical bill to prove it.

After my dad and I unsuccessfully tried to convince Jennifer to self-admit, we then turned to the two social workers sent by the County. Only problem was it took almost two hours for them before they could enter into Jen's apartment because we had to wait for the Buffalo

Police Department to arrive since the initial incident involved a knife. This of course made Jen get very antagonistic saying things like, oh, some emergency this is, they must really care, and things of that nature.

As I mentioned before, Jennifer was very, very smart, and so of course she did her due diligence on the resources that were available here locally, specifically ECMC, which is where most people are turned to, and was met with horror stories. Overcrowded, chaotic waiting rooms where people are left to wait for hours, and in some cases even days experiencing things that would further trigger and make their situations worse before they even get admitted, if they were even able to get in -- admitted in the first place.

She wasn't happy about it, but she knew how serious my dad and I were, so she was going to go along with it. Should've worked out. Prior to the social workers going inside, her partner Jake and I explained Jen's entire situation and made clear the fact that Jen was incredibly smart and would probably try to downplay the incident and talk herself out of it.

But again, we had all of this concrete proof.

The police eventually arrived and waited outside as the two social workers joined Jen, myself, and my dad inside. They questioned her for about 20 minutes or so before we were told that there was nothing they could do because they felt like she was doing this for attention. They also said that they couldn't do anything because Jen's actions may have been induced by alcohol, and New York treats mental health and addiction as two separate entities, which is insane to me because it is so glaringly obvious that these two issues are deeply, deeply intertwined with one another.

The social workers went on their way, and the only correspondence Jen had with anyone from Crisis Services or the County were several calls from ECMC incorrectly saying that she had a bill due to them for that day. I believe she received four of those calls, which only served to upset her further obviously. And myself, Jake, and my father received zero calls from anybody checking on her or following up with our family.

Less than two months after we were told

Jen wasn't suicidal and it was all for attention, she took her own life.

In New York, we are so lucky to have an incredible amount of folks who are social workers, psychiatrists, therapists, etcetera, so I want to make sure that my words aren't misconstrued as being targeted towards them. But we had all of this evidence that Jen was in the midst of a life or death battle, and I was told by them that there was nothing they could do because again in New York they treat addiction and mental health as two separate entities, and that threats of taking her own life could have been induced by alcohol. Hello.

So we're just going to leave people out to dry? We're going to abandon people at their darkest hour because they're struggling with multiple things at once and because we don't have the structures in place to support people who are dealing with these two deeply intertwined issues? Do we realize how twisted and short-sighted it is?

Addiction and mental health are not black and white issues, so why are we treating them as such? The failed intervention led to

Jennifer and I having a big falling out. I told my dad and Megan and Jake ahead of time that I would be the one to take blame just because of how close Jen and I were, and I knew she'd look for somewhere to place it. And I was fine with it being me because if it meant that she was going to get the help that she needed, then so be it. That's all that mattered at the end of the day.

The last time we spoke to each other was a huge argument over this, meaning we didn't speak for the last month and a half that she was alive. She felt like I was trying to get her locked up when in reality I love my sister more than anything, and everything I did was because I was terrified of losing her. And as I had said before, this was something that she was dealing with for nearly 20 years. And with me being five years younger than her, this is something that I was seeing firsthand since I was like eight or nine years old.

I -- Jen and I had fought plenty of times over the years. I mean, we're siblings, but this one was different because I knew the person on the other end of that fight wasn't my

big sister. She was so clearly not in a good place and not herself, and it felt like that this was the culmination of all the times in the past that we tried to get her help. But the light needed to go on for her to realize that she needed help. And even if my dad or myself couldn't convince her, we still just needed to get her the help regardless, and she was failed.

The fact that someone is brilliant and driven and talented as Jen couldn't get through her mental illness and resorted to this just signifies how deeply it was hurting her and how deeply mental illness and addiction affect people. My sister was capable of literally anything, and my heart is broken because I know to this day this very moment that she could have gotten through this and beat this.

But the pain that she was feeling was too heavy a weight to bear. And due to the complete lack of impactful resources, she felt like there was nowhere to turn and no way to get better. I promise I'm wrapping up.

The feeling that my family and all of Jen's loved ones have to live with now, this emptiness of her not being here when we all knew

Jen and knew that she could get better, that emptiness and feeling of hopelessness is something that nobody should have to go through. More importantly, we're talking about human beings here, and no person should have to feel as though there's nowhere to turn or no other options in a time of pain and crisis.

Do we realize the cruelty and the fact that this is so common? After Jen's funeral in which I gave her eulogy, I had a staggering amount of people come up to me afterwards saying how they appreciated and felt seen by my words regarding mental health due to themselves, their child, or a loved one dealing with similar issues to Jennifer.

According to the CDC, one in five Americans will experience mental illness in a given year. So whether it's us personally, a loved one, or someone you may know, every single person is touched by mental illness one way or another. We're all here today because we shared a common belief, that the resources and care for those struggling with mental health issues is not even close to being at the standard of where it needs to be.

The state of things as they are now is due to choices that were made by people in power previously. The inaction of those same people has led -- that has led to the current situation and all of us being here today. That's also a choice. We can't ignore the severity of this situation any longer because inaction in and of itself is a choice.

My sister may be gone, but if her memory and legacy can help change things so that people struggling and their families don't have to endure what Jen and my family has gone through, then we have to do it. We have to fight. We have to make the proper choice to be there for ourselves and for each other. Helping people is what Jennifer loved most, so what better way to honor her life than by helping people in need?

The fact of the matter is how swiftly we act will determine how many lives are saved, and how long we continue to wait will determine how many more lives are lost. Thank you for the opportunity to speak here today.

(applause)

AG LETITIA JAMES: So Ms. Pope, do you

have any suggestions for how we can attract individuals with lived experiences to the workforce?

TYLICA POPE: I'm sorry. Do we have any?

AG LETITIA JAMES: Any recommendations or suggestions on how we can attract individuals with similar lived experiences to the workforce? What are your thoughts?

TYLICA POPE: Absolutely, yes. We -- there are a number of -- well, here (indiscernible). At our agency, we actually employ individuals with lived experience. We have a workforce program for individuals just like me with lived experience, so we come (indiscernible) and get their certification, and they share that experience with us. So if you would like to track them down, we can help you with that.

AG LETITIA JAMES: Ms. Tobia, I have a picture of your son Matthew. If you could change the system, what would be some of your recommendations? And talk a little bit more about Medicaid, insurance, and discharge.

ELISA TOBIA: I'm still working on

getting the insurance records because they're ally pretty tight. My husband and I had court -- a lawyer prepare a power of attorney tat included all the health proxy, all the HIPAA, all the whatever. Rule number one I would have is if an individual states they have that and can bring that item into the provider, they dang well better accept it.

Statements to me, ma'am, were he has to sign off on that document when they arrive. Power of attorney is meant to protect and guide and advise, and it's COVID. And they wouldn't even validate that he had an appointment. And I said, ma'am, I'm calling you because I know he has an appointment. I'm trying to get -- I want to know when the appointment is, how the appointment -- you know, how is he going to -- just like the mechanics.

I don't want to know what they were talking about. I'm trying to get the kid in. There's got to be something to address the HIPAA factor. And when is the person helping to get them in a system and participate, and when is it interfering? Because it's a huge obstacle.

The issue of this law that I'm

proposing that Lanny Berman is part of with Maryland, and I have the entire document and all the people's testimony with it, it's really pretty remarkable because it takes every record, the very first two sentences protects everybody from liability. This is not to sue anybody.

AG LETITIA JAMES: Right.

ELISA TOBIA: This is a systemic look. We have to have ways that when people die, that we use those records for a purpose. That's what I'm trying to do as a parent, as an individual, because I needed to connect the dots. I needed for the case worker who called me and cried for four hours seeking forgiveness because she knew something, and she felt she didn't protect him. But I said, ma'am, did you have thus and such a record from -- she -- what record?

AG LETITIA JAMES: Mmm.

ELISA TOBIA: Are we going to persecute the counselor who didn't have the record? How do I know that? I've been looking into it. I spoke to the next provider. He did have a Honey provider too, so there is a way to track the documents in that. And when you open a folder and all it has is claims that were filed, no

action. I have the objectives. There is so much data there to go what part of this system is working and not working, right?

AG LETITIA JAMES: Right.

ELISA TOBIA: So the more I look and the more wounds that sort of come up, the more substantial goals and guidance that I can provide you with. But I tell you, Lanny Berman, he's a -- you know, he's an ace. Boy, I was on a zero suicide prevention line, and email, and he said I'm not out to witch-hunt anybody. I said neither am I. I got his CV. I got the law. And I was like you're kidding.

AG LETITIA JAMES: So when I worked in the childcare system a long time ago and when I worked in the state legislature, I helped with state legislature to draft a childcare fatality review board for children who die in childcare. And so basically it's -- what you're asking for is similar --

ELISA TOBIA: Sounds similar.

AG LETITIA JAMES: -- something similar.

ELISA TOBIA: Yeah. And they do it for domestic --

AG LETITIA JAMES: Right.

ELISA TOBIA: -- I believe we do it in the state for domestic violent death incidents of some. I don't know enough about -- but yes, it's in the same --

AG LETITIA JAMES: Very similar.

ELISA TOBIA: -- engine, right? The little engine that could, you know?

AG LETITIA JAMES: Exactly.

ELISA TOBIA: We talk a lot about things that we do to help people survive, but you know, we can't talk to the dead people, but boy, their records can sure tell us a lot.

AG LETITIA JAMES: And do you think your experience was limited to Steuben County, or this is a -- is this a statewide or a -- or it is just because you are in a county with -- less populated?

ELISA TOBIA: Well, I think there are circumstances related to Steuben County that I don't want to go on record here to say because I don't want to make false statements that I can't justify. But I'm involved with the National Alliance on Mental Illness, and the thing that really brought up my advocacy beyond my original

level was going to this state conference and meeting really, really good people talking about really, really good programs that are really, really in place.

And I was like, hello. Let me show you the documents. And it's why -- and still investigating why is it Steuben County did not have the capacity. I do know on record that they have stated to me, one individual, that the County will not invest in mental health directly. They will contract with neighboring counties and non-profits.

If you look on the SAMSA website, you will -- and Richard McKeon, who is the head of the Suicide 988 folks, because I shared with him the 741-741. A wonderful man. If you look at a diagram on the SAMSA website, and I can share the link to that, you will see services all the way around the perimeter of that county. We have providers from Livingston County jumping right over Steuben County going to Chemung County.

We have 988 has Steuben County as the orphaned. We weren't even put in a 988 region. I met up and met with them myself and said how are we getting Steuben County in. So is it all

Steuben? No, I don't think so. I think it's a state problem. I think it's a national problem. I think New York State has its uniqueness, and I do think we're in a position with the style you're using and this approach that we're going to ferret out what the issues are.

And I have confidence in your staff and all the providers and families that we'll get to it, and I feel hopeful. I really do feel hopeful.

AG LETITIA JAMES: Thank you. And thank you for your testimony.

ELISA TOBIA: Thank you.

AG LETITIA JAMES: Mr. Orr, your testimony was impactful, was eloquent, and heartfelt.

BRENDAN ORR: Thank you.

AG LETITIA JAMES: Any recommendations with respect to how to get some change given the fact that you indicated inaction by previous administrations, individuals that have long gone? What can we do?

BRENDAN ORR: I think it's really, for one, taking a look at again that intersection of where mental health and addiction meet. You

know, it's something that, you know, my sister wasn't like an anomaly with that. She was very -- it's a very common thing that people who suffer from mental illness in many cases in some form also deal with some form of addiction due to those mental illnesses that they're dealing with.

And so the fact of the matter is to be told, well, that -- that there's nothing we can do because her threats of her own life may have been induced by alcohol, well, Jake, Jennifer's partner, had said, well, what do you want us to call you when she's drunk. And they said, well, no, because then it's calling the police and then it's a criminal matter.

And so again, just the fact that these two issues that are so deeply intertwined with each other are being treated as two separate entities just does not make any sense to me. I mean, and again, as I'd mentioned at the beginning, Buffalo's a metro area of over a million people.

AG LETITIA JAMES: Right.

BRENDAN ORR: Okay. We're starting to see now from the last census that the population of the city is beginning to increase, and that

trend is going to continue. And the fact of the matter is, is what do we have in Erie County? ECMC and BryLin. BryLin is less than 50 beds. ECMC is not very many either. I mean, not a ton again for a metro area of this size.

And so -- and again, I think on top of that too the horror the stories that come out of those places. I know that it's been reported recently with regard to ECMC and how the treatment is there. And again, after Jennifer's funeral and in the aftermath of her death, the amount of people not only, you know, family friends, but Jennifer's friends too who have had experiences at ECMC where they were waiting over a day in a waiting room, and they just pile everybody in there.

And it's people of varying degrees of mental illnesses as well. And it's -- again, that's no in any way, shape, or form me trying to say something negative about the folks who work there because of course it comes down to staffing and to the resources that are available, structures in place, of course. But again, we're talking about top 50 major metro area here, and the amount of resources that are available to

people who are struggling with mental health issues, with addiction issues, and especially the intersection of those two, it's abysmal at best. And so we just -- we need more. There's just not enough for people, you know?

AG LETITIA JAMES: Right.

BRENDAN ORR: People shouldn't have to wait when they're in a time of crisis and they're thinking I feel like maybe I want to take my own life right now. People should not then have to go and sit in a waiting room for a day and a half and just have to like just be treated like a number, you know? There's no individualism when it comes to it.

We need to -- like I said, people are -- we're talking about human beings here, people who are in their darkest hour and struggling more than they ever have before. And to think that just people are getting turned away or being told, oh, there's nothing we can do, it's -- I can't even wrap my head around it.

And so I think it's -- again, it's a matter of addressing the two issues of mental health and addiction, and understanding that they are intertwined with one another.

AG LETITIA JAMES: Right.

BRENDAN ORR: But also, the fact of the matter is, is that there's just not enough resources here to begin with when it comes to people who are -- if they are just struggling with mental health to some -- mental health issues to some degree as well.

AG LETITIA JAMES: So Mr. Orr, a representative from the hospital will be testifying today, and we will ask them questions about the intersection between mental illness and individuals who are chemically addicted. I am familiar with what they refer to as micro services.

BRENDAN ORR: Mm-hmm.

AG LETITIA JAMES: And the question is whether or not those services are available at the hospital.

BRENDAN ORR: Mm-hmm.

AG LETITIA JAMES: And if it is a question of additional resources, what we can do, what my office can do, and all of those who are watching can do to increase those resources to the residents of Buffalo so that we will not have any further loss of life --

BRENDAN ORR: Certainly.

AG LETITIA JAMES: -- either Mr. Tobia and/or your beautiful sister.

BRENDAN ORR: Well, and I just want to say one other thing too with regard to that. When it comes to again just also -- you know, we're told when you're in a time of crisis or if you're seeing somebody who's experiencing mental health issues that you should reach out, that mental health matters. That's what we always hear from people. It's what we always hear from politicians.

But the reality of the situation is, that we all know, the reason why we're all here is because that does not actually add up with the actions of those people. And so another thing that I would just like to say too, I mean, to be told when I have watched my sister go through the wringer for 20 years and have memories burned into my brain from being 8 or 9 years old all the way up until now, and phone calls in the middle of the night, and going over at 4 in the morning, and being there for her for whatever it was she needed to then have somebody come and talk to her for 20 minutes after we lay all of this evidence

out and tell me that she's doing it for attention, I mean, what are --

AG LETITIA JAMES: That's painful.

BRENDAN ORR: -- you know, as a family member -- because that's the other thing too is, you know, family members in a lot of these situations, the fact of the matter is that the people who are suffering from mental illnesses, and in the case of my sister when it was getting towards the end and like down the stretch, like she was not herself. She was not of her right mind. Like she was --

AG LETITIA JAMES: Right.

BRENDAN ORR: -- really, really struggling and going through it. And for me, what I would love to know is what more could've been needed to get her admitted through this -- through these services if an -- like an act of doing it and a hospital bill and a gash on her face with stitches, if her -- in writing saying that she wanted to take her own life. And if her saying it out loud to multiple people was not enough, then what is?

AG LETITIA JAMES: Mr. Orr, did your sister present her illness at a -- as a child?

BRENDAN ORR: I mean, we really -- it was like early adolescence. I think is when it was like probably around like when she started high school. So like 13 or 14 --

AG LETITIA JAMES: Yeah.

BRENDAN ORR: -- I think is when we -- like our family kind of really -- my parents really realized it --

AG LETITIA JAMES: Yeah.

BRENDAN ORR: -- a bit. And there were many attempts like again, you know, over the years and stuff. But she was in a lot of ways just kind of like put through a system, and then she'd see a doctor, and she'd get put on medication. And then the --

AG LETITIA JAMES: Mmm.

BRENDAN ORR: -- medication wouldn't work. And then there'd be another doctor, another medication without actually examining, again, like, you know, what it -- how it was actually affecting her, and like what her needs really were. It's just a matter of it kind of being this like cyclical thing of, oh, this didn't work, then let's try this. Or try this medication.

And while of course this -- that is in no way, shape, or form me saying that folks who deal with mental illness that medication isn't an answer, because it absolutely is. It's proven that it can be for some people, and I think very well could've been for the case with my sister potentially too.

Even before she passed away, she was taking medication, but again, it was that cycle of, you know, well, try this, try this, try -- and when nothing was really sticking. It was just the bill was getting passed onto the next psychiatrist, the next person, what have you.

TYLICA POPE: Attorney General, may I add to that, please?

AG LETITIA JAMES: Sure. Sure, sure, sure.

TYLICA POPE: And so I just want to add that -- and again, I absolutely understand those systems, and I too have experienced that in the workforce and for myself. And what I want to say is that I think that part of -- there's a large problem happening with our community hospitals --

AG LETITIA JAMES: Yes.

TYLICA POPE: -- such as ECMC because

they don't have -- one, they're not always equipped to deal with individuals that come there. They don't have the staff. They don't have the training. And so service providers, community service providers, such as other behavioral health agencies, do have the capacity to support. And so that's why I was talking about peer services --

AG LETITIA JAMES: Right.

TYLICA POPE: -- being one of the things that's necessary and needed. Peers, individuals are going into the homes. They're going into the community. They're actually the individuals that will check with the families and talk about, you know, what's happening with your loved one and walk you through that.

And so that's why it's so important that we put our, you know, funding and supports where it matters, where you can get individuals to speak to those individuals, to address those individuals where no one's falling into those gaps of services. And so that's why I wanted to point out that, again, when we're talking about the hospitals not having the capacity --

AG LETITIA JAMES: Right.

TYLICA POPE: -- some of the agencies have the capacity and want to do the work. But again, we need staffing. We need after-hour facilities. We need funding to be able to have, you know, as we're talking about service centers that's open, community centers that's open --

AG LETITIA JAMES: Right.

TYLICA POPE: -- (indiscernible) center that's open 24 hours and longer shifts for us to be able to support individuals --

(applause)

TYLICA POPE: -- where the hospitals cannot. That's what's needed.

AG LETITIA JAMES: And Ms. Tobia, your son was introduced to opioids as a result of an illness, correct?

ELISA TOBIA: A sports injury, yes.

AG LETITIA JAMES: A sports injury.

ELISA TOBIA: A sports injury and shoulder surgery, yes.

AG LETITIA JAMES: Right. And as you know, our office has brought the largest --

ELISA TOBIA: Yes.

AG LETITIA JAMES: -- lawsuit against these opioid manufacturers.

ELISA TOBIA: Thank you, yep.
AG LETITIA JAMES: And one of the things that we are trying to do is get the resources out as a result of our settlement funds --
ELISA TOBIA: Mm-hmm.
AG LETITIA JAMES: -- to all the counties in upstate New York.
ELISA TOBIA: Yes.
AG LETITIA JAMES: And you can rest assured we will make sure that Steuben County is on the list so that they get additional resources.
ELISA TOBIA: Well, did you say additional?
AG LETITIA JAMES: Additional. Or --
ELISA TOBIA: Okay. Thank you.
AG LETITIA JAMES: -- resources.
ELISA TOBIA: Thank you. And I'd be happy that we track the money. I had a conversation -- we're given a five and a half percent tax break in the county property owners.
AG LETITIA JAMES: Mm-hmm.
ELISA TOBIA: Even though we have increased expenses all the way around, and I

talked to the county executive. I mean, how do you give a five and a half -- you know, like these things don't add up. Statement, our legislature believes that they have given enough to mental health this year. On the back of what, the opiate funding? Like let's chase the money here. What are you guys doing? How do you -- makes no sense to me. No sense.

The vacancies within the county are absurd. They tell the legislature we have all of these openings. Why am I not finding them on the Steuben County website as civil service positions?

AG LETITIA JAMES: Mmm.

ELISA TOBIA: I see RNs for the health department during COVID. I see the snowmen. I don't see psychiatric nurse practitioners. I don't -- they're not there because it's all subcontracted out to non-profits --

AG LETITIA JAMES: Right.

ELISA TOBIA: -- and they're suddenly realizing that they're not paying folks enough money. So they just decided, well, we'll bring two positions, and it's in the legislative notes. Requesting that we put two positions of licensed

clinical social workers who can accept Medicaid and standard insurance. They finally figured out that if you have a qualified person who can accept insurance, you might like get at least some of the money. And a legislator says how much is it going to cost me.

AG LETITIA JAMES: I thank you for your testimony.

ELISA TOBIA: But thank you for the extra. Thank you for the --

AG LETITIA JAMES: I appreciate it.

ELISA TOBIA: -- extra money. That's terrific.

AG LETITIA JAMES: And may both of your loved ones rest in peace. And Ms. Pope, thank you for serving in your capacity. And thank you for healing.

TYLICA POPE: Thanks for having us.

ELISA TOBIA: Thank you.

(applause)

AG LETITIA JAMES: Thank you for the wait.

AAG STEPHANIE CALHOUN: We will now hear the testimony of Chairperson April Baskin and Laura Kelemen.

APRIL BASKIN: Greetings to friends, colleagues from Buffalo and Erie County, and Attorney General James. Thank you for providing this much needed space to discuss mental health in western New York. Again, my name is April Baskin, and I am the Chairwoman of the Erie County Legislature.

Erie County, like all other counties in New York, is responsible for administering a local comprehensive planning process to ensure such mental healthcare is properly coordinated among the various providers in our county. Erie County has many resources for those who have access to mental health treatment.

Our major issue is not insufficient resources, but the barriers to access and tailor-made treatment programs to cover all aspects of mental health treatment and its spectrum. We have begun to make strides in re-envisioning how treatment programs are provided. In 2019, the legislature approved $1 million in the Erie County budget to implement a medically assisted treatment, also known as MAT Program, in our county jails.

This was in response to the severe

opioid epidemic we are dealing with Erie County, and the clear overlap between substance abuse, mental health, and incarceration. The MAT Program was launched this past summer, and the demand from detainees to access the program continues to grow.

Following the decision to fund the MAT Program, our county had to confront the trauma of the pandemic and the civil unrest following George Floyd's murder. These episodes aggravated already stressful situations for many residents who struggle from paycheck to paycheck and scramble to survive. These traumatic incidents helped shine a light on the systemic issues our residents face, namely a lack of easy access to mental health treatment.

In September of 2020, a call to 911 was made regarding an individual having a mental health crisis, which ended with the individual being shot by Buffalo Police. After this incident, the legislature introduced a resolution to look into the need to have mental health first responders, particularly with non-law enforcement response as an option.

Erie County is responsible for intake

of all 911 calls made by a cell phone in Erie County. Then they are dispatched to the appropriate jurisdiction and the first responder, be it fire, police, or EMT. As Erie County is the initial agency to handle most 911 calls, the legislature thought it was appropriate to look into this issue.

A few weeks after this incident, the legislature convened a meeting with the Department of Mental Health, the Erie County Sheriff's Office, and directors from Erie County Medical Center's comprehensive psychiatric emergency program to discuss the implementation of the MAT Program, the possibility of a 911 diversion initiative, and other gaps that may exist in our county's mental health network.

One potential solution that was discussed was the need for a behavioral health center that could address mental health needs outside of the hospital framework. Additionally, we discussed the need for a behavioral health mapping effort to best identify what resources all right currently available and what gaps still exist.

Following these discussions, the

County's Mental Health Department, under the leadership of Commissioner Mark O'Brien an innovative project called the Respite and Recovery Center was brought to the legislature's attention. This center would address a wide spectrum of needs and behavioral health and house multiple kinds of mental healthcare under one roof.

Someone could stop in for a few hours and talk to a peer if they are feeling down. They could also spend a few nights or begin short term treatment. Or for those in most need, they could be admitted and stay up to two weeks in a longer term care setting. The county legislature decided to identify funding and supported this center with a $100,000 investment.

While all of these treatments are currently available in Erie County -- the center is scheduled to open later this year. While all of these treatment that would be in this center are in this proposal are made available to and in some way in Erie County already, this center was an innovation, and it provided a greater flexibility to address our local mental health crisis.

Today the center is known as the Kirsten A. Vincent Respite and Recovery Center named in honor of the former CEO of Recovery Options Made Equal, who led the charge for the creation of the facility.

Erie County has continued its work on mental health and first response with its Police Reform Citizens Task Force report and recommendations. The task force recommended the creation of a Crisis Services Response Team to develop a plan to respond to mental health crisis calls. The report also prompted the question of whether calls should be responded to by law enforcement or by a Crisis Service Response Team. The plan and the Crisis Service Response Team have yet to come together, but hopefully we will make progress in 2023.

Most recently, Erie County was confronted with the immediate trauma of a racist terrorist attack. The County was quickly able to assemble a mental health hub in the immediate neighborhood of the attack, and provided easy access to mental health professionals as well as counseling onsite services for free.

This hub demonstrated the County's

ability to respond to mental health needs in an immediate fashion, but it was just a short-term solution to deep-rooted structural and systemic issues shrouded in racism. Under my leadership as Chairwoman of Erie County, we have done an immense amount of work and mental health research reform.

And in closing, I hope these examples show why Erie County has to expand access and reduce barriers to mental health treatment. I think we have made great strides, but we need to continue the momentum to provide mental health assistance to our constituents. One of the main questions at hand is what role does local government play in providing direct response and direct services for mental health crises.

We have launched pilot programs for diverting self-reporting mental health 911 to a mental health agency, and we've done the same thing with co-responder models where mental health professionals accompany law enforcement on patrol. But are these efforts enough, or do we need a more direct, more proactive mental-health-professional-led effort actually housed in county government? I hope we'll continue to ask these

questions, and I look forward to your input, Madam Attorney General, as we continue to work on this vital issue. Thank you again for holding this important hearing on mental health in the great County of Erie. Thank you.

AG LETITIA JAMES: Thank you.

(applause)

LAURA KELEMEN: Attorney General James, thank you for you having us here today.

AG LETITIA JAMES: Thank you.

LAURA KELEMEN: And we appreciate the work that you do. My name is Laura Kelemen, and I am the Director of Community Mental Health and Substance Abuse Services for Niagara County, and the chair of the New York State Conference of Local Mental Hygiene Directors.

The conference was created pursuant to Section 4110 of the Mental Hygiene Law, and its members are the directors of Community Services, DCS, for the City of New York and each of the other counties in New York State. Under the statute, the DCS is responsible for local government's mental hygiene policy, and the DCSs are responsible for planning, development, implementation, and oversight of services for

adults and children in their counties who are affected by mental illness, substance use disorder, and intellectual and developmental disabilities. Our mission is to facilitate the health and well-being of our constituents.

AG LETITIA JAMES: Ms. Kelemen, can you move the mic closer to you?

LAURA KELEMEN: Sure.

AG LETITIA JAMES: Thank you.

LAURA KELEMEN: Is this better?

AG LETITIA JAMES: Yes, ma'am.

LAURA KELEMEN: Excellent. So our mission is to facilitate the health and well-being of our constituents, and our job as we interface with all sorts of systems, health, and social services systems is to solve system problems. Because one life lost is one too many.

We're here today to talk about the fact that the foundations of our community mental health system are crumbling due to lack of workforce and longstanding inadequate funding. We continue to seek to expand our range of services with fewer staff, but to what end? Our outpatient clinics have vacancy rates from master's level therapists ranging from 25 to 40

percent. It's worse in the rural areas.

Agencies have been forced to decrease or eliminate same-day access to services, and individuals are experiencing longer wait time in between appointments. Some agencies have not been able to reopen school satellite clinics since the pandemic. Experienced clinicians are leaving for higher paying jobs in private practice, insurance companies, and with the telehealth industry.

Staff left behind are often inexperienced, overburdened, and it contributes to further burnout and attrition. The care of individuals receiving services is significantly disrupted when their trusted therapist leaves.

Other people have referenced the hospital system, which is overburdened and over-resourced. New York State has had a planful reduction in bed capacity at their state inpatient facilities. Unfortunately, due to lack of staff and inadequate reimbursement methodology, worse than the rural communities, the development of the envisioned community programs, which would've supported individuals with serious mental illness in the community, has

not occurred at the rate and scale needed.

And so without community wraparound services and outpatient clinic programs, individuals in crisis end up needing emergency services, or worse yet, interface with the criminal justice system. Others have referenced the hospital bed capacity concerns. I'm aware that approximately 70 beds are currently offline due to staffing issues dating back pre-COVID. So we're concerned about getting COVID beds taken offline. Staffing was an issue prior to COVID.

The Erie County Executive mentioned the long stays in emergency departments. We share those concerns because lengthy stays exacerbate mental health symptoms, and subjecting those in crisis to extensive wait times is simply cruel and inhumane.

But let's talk about the criminal justice system for a minute. Increasing numbers of individuals with suspected mental health conditions are interfacing with law enforcement. We've had an increase in CPL 730 competency examinations 20 percent since last year versus pre-COVID. We cannot condone a system of care where the court system is an entry point for

treatment.

AG LETITIA JAMES: Mm-hmm.

LAURA KELEMEN: Unfortunately, DCSs are seeing massive increases in the issuance of 730 competency restoration orders that place individuals with serious mental illness into state forensic facilities at 100 percent cost to counties. This syphons millions of dollars from local county budgets that could be used for community based programs or prevention efforts.

We are pleased to hear the governor's plans during her State of the State address to invest $1 billion into the state's mental health systems. However, we advise caution. Local planning -- locally driven planning is needed to be able to effectively target resources.

Additionally, we must shore up the foundations of our mental health system through righting our hospitals and providing resources for outpatient treatment as well. I appreciate the opportunity to be here. I, of course, have lots of suggestions for how we might be able to address this, but I'll leave it open for questions you may have.

AG LETITIA JAMES: Thank you. So Ms.

Kelemen --

(applause)

AG LETITIA JAMES: -- let's start where you ended, Section 730. Walk me through the process. What happens?

LAURA KELEMEN: So what happens is when somebody is suspected of having a mental health issue and is -- the question is whether they are competent to stand trial.

AG LETITIA JAMES: So this is at arraignment.

LAURA KELEMEN: This is either at arraignment -- well, it could happen at any time in the process, but let's say it's at the first couple of court appearances.

AG LETITIA JAMES: Okay.

LAURA KELEMEN: If there is some question about whether they're -- because of mental health concerns or a developmental disability they are able to understand the nature of the charges against them, or participate in their own defense, the court orders competency evaluations. That gets done at the local level.

If somebody is deemed incompetent, typically speaking, at a misdemeanor level, those

charges can be resolved, and a person can be evaluated at a local psychiatric center, such as Buffalo Psychiatric Center.

AG LETITIA JAMES: And these are individuals who are out on bail or in bail, are in jail?

LAURA KELEMEN: Either one.

AG LETITIA JAMES: Either one. Okay.

LAURA KELEMEN: Either one. Yes. If a person or if the situation warrants that the case will move forward to trial, an individual would -- and that could be because of certain felony charges. There's a lot of rules around it. Certain felony charges it's a requirement. A grand jury indictment I believe it's a requirement.

If a person will be moving forward with trial at some point, that person whose mental illness at that moment prohibits them from understanding the nature of their charges or participating in their own defense, will be sent to a state forensic locked inpatient psychiatric facility. They do not receive actual treatment there. I'm sure there's wonderful psychiatrists who are working with them, so I don't mean to --

AG LETITIA JAMES: No.

LAURA KELEMEN: -- say that folks aren't receiving care. But the purpose of that care is restoration so that a person then is competent enough to stand trial.

AG LETITIA JAMES: So it's temporary.

LAURA KELEMEN: It's temporary. However, that restoration process, sometimes the orders are for 90 days, but a restoration process could be a year, two years, five years, ten years. There's no specific at this moment in the law --

AG LETITIA JAMES: Mmm.

LAURA KELEMEN: -- determination of how long that process can go. If it goes on long enough, what's called a Jackson plea can be brought forward so a person can't stay in for more than two-thirds of the potential sentence they would've gotten had they been sentenced.

But one of the things that would be extremely beneficial is if the court were able to, on a routine basis, bring defendants back and the treatment team together to discuss how things are going in the process of restoration.

Prior to sending somebody for

restoration, it would be ideal if there could be an estimate of the length of time that restoration might be able to take place.

AG LETITIA JAMES: And those costs are borne by the locality.

LAURA KELEMEN: One hundred percent by the counties. And so this becomes a budgetary nightmare.

AG LETITIA JAMES: Yeah.

LAURA KELEMEN: We have zero control over how many requests for a competency evaluations we'll get in a year. We have zero control over the number of those competency requests that are scheduled for restoration because somebody comes back showing incompetent to stand trial.

And certainly we don't want people whose mental illness is getting in the way to be forced to stand trial. And we have zero control over the length of stay. It's 100 -- it's $1,109 per day per person.

AG LETITIA JAMES: And as far as you know, is there any state initiative, legislation so that the State would pick up those costs as part of that $1 billion initiative?

LAURA KELEMEN: Both the senate and the assembly do have bills presently.

AG LETITIA JAMES: Okay.

LAURA KELEMEN: It's Senate Bill 7461-A out of Brooks' office, out of the assembly out of Gunther's office. It's 8402. And essentially, that would look to restructure the state's CPL 730 law. It would place a limit on the amount of the length of time that counties would be 100 percent responsible.

But more effectively, it would also push us to examine is restoration likely. What is the length of that restoration? And if localities will be saving money due to not having to pay for those services, we can then reinvest those dollars back into the communities for either programs or prevention.

AG LETITIA JAMES: And Ms. Kelemen, we're at this point in time primarily having a budgetary discussion. What about getting services to that defendant, that individual, that human being? Do they get services during that period of time?

LAURA KELEMEN: That's a tricky question.

AG LETITIA JAMES: Okay.

LAURA KELEMEN: So when people are in the local county jails, services are typically provided in the local county jails for individuals. Sometimes people are on pre-release supervision or involved with some kind of release prior to the court hearing --

AG LETITIA JAMES: Dispositions, yeah.

LAURA KELEMEN: -- disposition, thank you. It's a little bit trickier to ensure that individuals in the community are actually receiving services that are necessary. Many times those services are voluntary. And if people are choosing not to be involved in those services, they're choosing not to be involved in those services.

AG LETITIA JAMES: And you also talked about wraparound services, the lack of wraparound services. That too is a resource issue, correct?

LAURA KELEMEN: Correct. Not enough staff, inadequate funding methodologies. Worse in the rural communities, no offense to Erie County or to the city of Buffalo, but distance to travel to get from place to place to place, and the time in that distance limits the number of

people that you can reach effectively in any particular day.

AG LETITIA JAMES: And Madam Chair, do you know whether or not the nation 988 crisis line has been rolled out in your county?

APRIL BASKIN: That's something that the last I heard is currently being worked on, yeah.

AG LETITIA JAMES: Okay. And what impact has the closing of all of these hospitals had on your county?

APRIL BASKIN: Same. That's an answer, Madam AG. I mean, I feel that the county -- more mental health actions is definitely a trickle-down effect of -- into poverty and to be people being able to be well enough to advocate for their family's needs. And what we're seeing is just an increased cycle of people being at a level of despair when it comes to being the status quo.

I believe the City of Buffalo and all throughout Erie County, even our rural areas, as chairwoman I do, do a lot of work with poverty initiatives in the rural areas, and I understand he needs out there as well. If we don't tackle

people's mental health access and eliminate the barriers, such as travel and people who are readily accessible to be able to address a mental health episode, unfortunately, the poverty stricken communities are falling deeper into poverty.

People are being turned over to our criminal justice system unjustly because they are sick, not criminals. And it's just causing blight and causing Buffalo and Erie County not to become everything that we can become as a regional entity.

AG LETITIA JAMES: To my -- go ahead, Gina.

AAG GINA BULL: Thank you so much for your testimony. We've heard some really disturbing stories from individuals in Erie County and Niagara County about children specifically, which I don't think was -- either of you discussed too much. So I was wondering if you could talk a little bit about where there's a dearth of services for children, whether it be residential treatment facilities, inpatient beds, or community based services.

Because we hear about so many children

who go to the ER and stay there for so long because they have nowhere else to go. And what does the State need to do to resolve those issue?

LAURA KELEMEN: I'll start if that's okay. We have seen, as was mentioned earlier, in 2019 the 12 beds that served children and adolescents in Niagara County in their inpatient program were eliminated by the particular hospital. It was a funding issue. So that's put additional strain on resources that exist in the area.

Individuals who -- children and youth who have particularly co-occurring mental health and intellectual and disabilities are ending up stuck for days and weeks and months in the emergency departments without effective places for individuals to go safely in the community.

It's an extreme concern that we have. A couple of things come to mind, which we need to do. Civil service has some barriers relative to staffing for county entities that employ civil service workers in the mental health field and in the state psychiatric facilities.

So for example, as a licensed clinical social worker, I've taken many exams to get my

licensure. I take many CEUs to maintain my licensure. But in order to work as a clinician in a state setting or in a county setting, I have to take more exams.

AG LETITIA JAMES: Mm-hmm.

LAURA KELEMEN: And so that creates barriers that if that were eliminated or updated, that could bring more people to the table today. We need to --

(applause)

LAURA KELEMEN: And that's just not licensed social workers. That's mental health counselors. It should be anybody with a professionally held licensure that had to take exams. We need to reform the civil service system, so we don't have to continue to take more exams.

AG LETITIA JAMES: Mm-hmm. Got it.

LAURA KELEMEN: It's an unnecessary barrier at this point.

AG LETITIA JAMES: Mm-hmm.

LAURA KELEMEN: We can look to our SUNY schools, and is there a way to incentivize SUNY schools to admit more MSW students, LCSW -- LMHC students, nurse practitioners, etcetera,

etcetera. Can we make scholarships more readily available and tuition assistant programs easy to navigate? Without easy-to-navigate programs, people don't go down that road.

So and I know that one's a longer term solution, but I think right now we have to think both short term and long term solution. The state O agencies are staring to talk together, which is really fantastic. And so more opportunities for Office of Mental Health, OPWDD, and Oasis. I know some people were talking about the intersect between mental health and substance abuse earlier.

AG LETITIA JAMES: Right.

LAURA KELEMEN: The more opportunities we have for our O agencies to collaborate amongst each other to develop programs, to collaborate with the local commissioners and directors of mental health and substance abuse services, we will get there. We just have to facilitate those opportunities and make sure funding for pilot projects is readily available.

AG LETITIA JAMES: So Ms. Kelemen, I hate to interrupt Gina. Is there is an interagency?

LAURA KELEMEN: Yes.

AG LETITIA JAMES: There is an interagency organization. What is it called?

LAURA KELEMEN: So there is what's referred to as the IOCC.

AG LETITIA JAMES: More acronyms. What is that? I don't know.

LAURA KELEMEN: I believe it's literally the Interoffice Coordinating Council.

AG LETITIA JAMES: Okay.

LAURA KELEMEN: For a while, that body had just not met actively. They would review certain appointments for positions, such as my own, but they weren't necessarily engaging in active discussions. They recently under the leadership of the three O agencies right now, but Commissioner Sullivan has really spearheaded bringing those organizations together.

The Conference of Local Mental Hygiene directors, IJO crashed their party a couple of months ago. We were invited, and we had some very robust discussions that started talking about workforce and the cross-system needs.

AG LETITIA JAMES: Well, I don't know about you, but if you and I want to crash their

next party...

LAURA KELEMEN: I'm in.

AG LETITIA JAMES: (Indiscernible).

(applause)

AAG GINA BULL: Ms. Kelemen, I think you're right about these long-term solutions we need to look about -- look at, but in the short term, what are we doing to make sure children who are in the ERs for weeks and months are getting education services, everything that they need? Because we know that children with disabilities, if they fall behind, even if just for weeks, they can't make that time up.

LAURA KELEMEN: One of the things that we're doing with our local hospital systems and our single points of access and the service providers is we have weekly sometimes biweekly meetings every -- twice a week meetings to discuss what's happening with each individually identified child so that we can try to build the service system around them.

We can try to find resources where we can't find resources so that we can successfully get a person to a safe discharge. So we're working tirelessly. One of the other concerns

that we have that we're just starting to talk to our hospital systems about, this is a huge barrier, if a child is seen at Niagara Falls Memorial Medical Center, for example, in their emergency department, and the ED there evaluates and determines they need inpatient level of care, Memorial doesn't have inpatient level of care for children and youth.

So that person has to be transferred to a different hospital system. Because of the lack of available beds, finding beds is next to impossible. And if a person does find a bed, they then have to be transferred to a different emergency department to go through the evaluation yet again.

AG LETITIA JAMES: Mmm.

LAURA KELEMEN: So then families are faced with -- they have other children, they have jobs, they need to put food on their table. And they're faced with having to go to communities that they're not familiar with. Maybe they don't have transportation there. To go through yet another emergency department evaluation to maybe then be admitted to the hospital.

It's a longstanding barrier that we're

just starting to have discussions on fixing. But without enough beds, I don't know how we fix it.

AAG MICHAEL REISMAN: I just want to follow up on -- and you may not know the answer to this question, but the scenario you've just described, and you've heard this from others about this sort of, you know, need inpatient care and can't get it at hospital A. Hospital B may or may not have it. Have to wait, have to go through the ED, start -- really basically start the process over again.

Does this happen for medical services? So if someone has the need for a medical treatment, cancer, does this sort of thing happen where someone has to go through all of these steps to get the treatment that they need?

LAURA KELEMEN: I'm going to say not to my knowledge. You may want to save that question for some of your physicians that you're going to talk with. But some things that don't happen, for example, for our -- we have a mobile crisis team, and lost of communities have mobile crisis teams.

Our commercial ambulances are declining transports of people who are having mental health

crises. They put them at the bottom of the acuity list. A person who's having a heart attack will get a transport, but -- and I started my fight back, you know, when I came to the County eight years ago. We were transporting people to the hospital in the back of cop cars, right? We don't want to do that.

We want to have them in ambulances, so we fixed that problem, and ambulances were taking our people in mental health crisis because it's a medical crisis --

AG LETITIA JAMES: Right.

LAURA KELEMEN: -- to the emergency room. Our commercial ambulances, due to their lack of staffing, are declining to take people who are suicidal, life-threatening crisis, to the hospital. So now we're transporting in the back of cop cars.

AG LETITIA JAMES: Mmm.

LAURA KELEMEN: At least they're getting to the hospital, but that's a terrible message to send to somebody who's having a medical crisis.

AG LETITIA JAMES: I thank you for your testimony.

LAURA KELEMEN: Thank you.

AG LETITIA JAMES: Very, very helpful. Thank you.

(applause)

AAG STEPHANIE CALHOUN: Good afternoon. I'd like to introduce the next panel. Erin Melfi, Dr. Victoria Brooks, Dr. Kenyani Davis. I just ask that you speak close to the microphone so that everyone can hear you. And be mindful. You may hear a beep at the conclusion of your testimony time.

ERIN MELFI: Okay. Good afternoon.

AG LETITIA JAMES: Good afternoon.

ERIN MELFI: My name is Erin Melfi. I'm a licensed art therapist working in private practice at also at BryLin Hospital, a private psychiatric hospital in Buffalo, New York serving children, adolescents, and adults. I am also a member of 1199 SEIU.

AAG STEPHANIE CALHOUN: Speak up a little bit more. Thank you.

AG LETITIA JAMES: You're a member of 1199. I know you can talk with a street voice.

ERIN MELFI: I'm new to this. I'm new. I truly appreciate the work that the Attorney

General's Office is doing to highlight the need for more and improved mental health services. For those that are not familiar with art therapists, we are master's level clinicians licensed through the Department of Education. We are required to complete a master's level program, 1,500 supervised clinical hours, and to pass a test all required by New York State.

We attend continuing education courses alongside mental health counselors and social workers, and we pay our yearly fees to New York State. What sets us apart from other clinicians is the use of the creative arts as an alternative form of emotional expression in collaboration with traditional therapy to help those we serve.

I enjoy my work as an art therapist and appreciate the opportunity to work with people to live healthier and more fulfilling lives. Unfortunately, this is difficult to do in an environment where providers are expected to do more and more with less and less. In my experience, mental health therapists and staff will tell you there is often more emphasis on healthcare as a business than the quality of care they provide.

This kind of pressure leads to stress, burnout, and high turnover among staff. We need to get back to quality, trauma-informed therapeutic care, and that takes times, but also improves lives. This is the care we were all trained to provide, and it's the kind of care we know works. If we could do this in an ethically sound setting, which promotes growth, where we can be paid fairly and treated kindly, therapists would be lining up for job openings and staying in those jobs.

Last week Governor Hochul announced she wants to invest $1 billion to tackle the mental health crisis we have right now, including opening up more psychiatric beds. And so I'm glad that the governor has made this a priority. However, there has to be recognition that we the frontline mental health workers will be the key to improving mental health services.

If we don't have the time to do our jobs and the wages to keep and attract more staff, opening up more beds or outpatient services will not succeed. On that note, I would like to express my disappointment with a recent bill, Bill A1171A recently passed by the

legislature and signed into law by Governor Hochul. This bill expands healthcare insurance coverage for outpatient mental health providers while specifically excluding creative arts therapists.

We make up approximately 14 percent of licensed New York State mental health providers, meaning that would've allowed New York state residents access to around 1,600 more outpatient mental health providers. The mental health crisis is fundamentally about not having enough professionals and staff to meet the need. Excluding over 1,600 potential providers undermines the state's ability to solve this crisis.

I hope lawmakers will included expanded coverage for our therapists when they take up the governor's call to tackle the mental health crisis. Thank you for your time.

AG LETITIA JAMES: Thank you.

(applause)

DR. VICTORIA BROOKS: Good afternoon, Attorney General James. My name is Dr. Victoria Brooks. I am the medical director of Erie County Medical Center's Comprehensive Psychiatric

Emergency Program or CPEP. I truly appreciate your interest in improving access to mental health treatment for western New Yorkers, and I really appreciate the opportunity to be able to provide input into this process. So thank you. Though I have also submitted a written testimony, today's comments will be an abbreviated version of that testimony.

Working in CPEP for the last 17 years, I have seen our department grow both related to an increase in the need for crisis intervention and emergent psychiatric care, but also as ECMC has endeavored to meet that need for our community, which now includes visits by denizens of many neighboring counties due to lack of services in those counties.

Due also in part to delays in discharging patients to state-supported programs sometimes for weeks to months coupled with inadequate Medicaid reimbursements, ECMC also continues to experience high patient volume challenges to our CPEP.

As the largest provider of behavioral health services in western New York, ECMC has advocated for more funding and greater access to

outpatient services and long-term psychiatric beds for years. Given recent financial losses attributable to behavioral health services for ECMC and other hospitals across the state to expand capacity, significant increases are needed for inpatient reimbursement as well as state funding for capital improvements to achieve that goal.

We're hopeful that Governor Hochul's recently announced plan to increase access to mental health resources will help reduce overcrowding in psychiatric emergency rooms across the state. We in CPEP continually work to identify areas of improvement both internally and within the larger system of care.

Incorporating feedback from patients, families, and regulatory bodies into ongoing quality improvement projects, we will certainly continue our internal efforts. Meanwhile, we regularly do and will continue to work with all patients who come to clinical attention in crisis, but we believe that proactively attending to patient needs in the community and bridging gaps with existing care providers in part through improved communication with and maintenance of

collaborative partnerships with those community agencies should be a priority.

Simultaneously, though, broader attention paid to systemic gaps through tighter system oversight may reduce the potential need for emergent care and enhance engagement in community based care outside of hospitals by minimizing dropout rates and facilitating early and urgent access to prescribers for medication management.

The development of supportive residential treatment and other intermediate levels of care has potential to facilitate hospital discharge planning and minimize recidivism while maximizing comprehensive follow-up with the community based system organized to manage that care, without which the outcome is invariably decompensation and inevitably the return to acute hospitalization or worse.

Supporting the police response to mental health related calls by instituting the behavioral health response teams in a growing number of local jurisdictions has shown promise in diversion efforts, but cannot independently alleviate the need for agency specifically on-

call systems accountable for patient care without which there is no alternative at night or on weekends to CPEP, which fragments care in an insufficient way.

Because we appreciate the potential traumatization inherent to crisis care and involuntary admission to a locked unit, we recognize all efforts to support diversion from the emergency room whenever is possible. Continually generating and participating in efforts to develop such alternative crisis care opportunities ourselves.

ECMC has invested and raised almost $2 million from private philanthropy to grow our help center urgent care clinic and our intensive outpatient program. It speaks volumes that we had to independently raise money for these services because they are not reimbursed by the state or our private peers at levels that would sustain these vitally important transition-level behavioral health services.

Improvement to the access of mental healthcare in this community will first and foremost require adequate reimbursement for services. We will also need involvement of not

only healthcare providers to produce solutions, but coordinated collaboration with law enforcement, multiple county and state agencies, in addition to political energy to reduce the potential for fragmented care, and encourage accountability for the health of this community.

Although often at the center of problem-solving conversations, our CPEP program should not serve as the sole focus or independently bear the onus of responsibility for our larger system. ECMC will (indiscernible) represent our place within that system, however, embracing our mission in continually striving to provide the most therapeutic, comprehensive psychiatric assessment and referral resource we are capable of in continued collaboration with all other agencies each working together to integrate the system of care around us, of which we are all a part. Thank you.

AG LETITIA JAMES: Thank you.

(applause)

DR. KENYANI DAVIS: Good afternoon.

AG LETITIA JAMES: Good afternoon.

DR. KENYANI DAVIS: My name is Dr. Kenyani Davis, and I am the proud Chief Medical

Officer at Community Health Centers of Buffalo. We are a federally qualified health center that spans over two counties here in western New York, so I'm here to give you two.

AG LETITIA JAMES: Okay.

DR. KENYANI DAVIS: I did submit a written statement, but really what I want to do is have an open conversation and a dialogue about that open statement because I think that's what you came here for.

AG LETITIA JAMES: Yes.

DR. KENYANI DAVIS: And the three points, just to be succinct, it's appropriate linkage to care, coordinated care, and I need to talk about my incarcerated people. So the first thing that I want to talk about is the intersectionality between primary care and mental health.

I got you from the cradle to the grave. So when they can't get into psychiatry, they can't get into CPEP, they can't get into BryLin, I got you. When we can't piece out their mental health in between their alcoholism, I got it. But we don't have the infrastructure in place, the reimbursement in place. I'm a federally

qualified health center. I can't have two services delivered in one day.

So when Mr. Orr's Jennifer comes in to see me and she tells me that she's ready to kill herself, but I'm also tending to maybe her chronic disease, and I need my behavioral health team to come and see them, I can't bill for both of those services. But being a federally qualified health center, we do it anyways. We do it for free.

A lot of times that -- the mental health providers that we have, the care coordinators, the case managers, that comes out of our very thin operation budget. Or that comes from the 340(b) money that we get that's under attack.

AG LETITIA JAMES: Mmm. Mm-hmm.

DR. KENYANI DAVIS: We still do the work because we've got to show up. I don't have the luxury as a primary care physician to say, you know what, that's somebody else's job. Or you just have to wait until you get into psychiatry because my community is hurting. We have over 20,000 patients, and with 80 percent of them are African American. The other 20 percent

make up the refugee health, and you talk about disenfranchised populations, I got it.

And the one thing that I want to make very clear is I hear all the time, and especially in this bill, we say open up more beds. But is that the right place for the right people? Because we've heard testimonies. And I can tell you -- I can give these patients names because they're my patients. Not everybody needs an inpatient psychiatric bed.

We always talk about communities from a deficit perspective. Communities have assets. The drop-in clinics that Chairwoman April Baskin was talking about, and other people were talking about, peer support. Sometimes these patients are -- these people are dealing with how do you pay your Section 8 rent? You got WIC that's coming in. I got three or four kids. All I need is respite care. Is that CPEP that I send them to? They can't sit in my office. Where can I send them?

One of the things that I always talk about is access versus connectivity, and do not think that they are both the same. Access is build a building and they will come. But if the

people don't feel connected when they go into that building, then what is the point? You have a beautiful lobby. Connectivity, physician recommendation is the number one thing to link. I've got patients who have been in psychiatric for a minute who are schizophrenic and I can't even tell you what their true diagnosis is.

I can't even tell you what their medications are. But guess what I got. I got the problems associated with that medication. Do not think for one second that primary care is not a part of this conversation. Because in medicine everybody's favorite word is --

(applause)

DR. KENYANI DAVIS: -- go see your primary care doctor. When you're feeling bad, where do you go? When they don't know where to show up, they come in my office. I need a reimbursement structure that supports that. 514 trauma, it's not what I read about. I was there. I got a call from my CEO. Was actually in Target, by the way. She said I don't know what we're going to do, but we've got to go. We'll figure it out when we get there.

So I have an entire community that is

traumatized that will live with them for the rest of their life that will continuously come into primary care. Continuously. The body keeps the score. If you haven't read that book, you should. It manifests as diabetes and hypertension.

And really what we're talking about is we're talking about the small percentage of people that become hospitalized that increase your cost. But I see them before they increase your cost. I just don't have any place to put them.

And lastly, incarceration. When they come out of the prison population, everybody thinks it's the physical health that I have to tend to. It's the mental health that I have to tend to. Because when we close down psychiatric facilities, this is where we put them. They come and they see me. I can't even get to the hypertension because I'm going to tell you a story about one of my patients who I seen right after incarceration.

I couldn't even get to what he was being treated for because I had to reorient him that it is okay to walk in the room. I don't

have to tell you to walk in the room. That stigmatization, that trauma that unfortunately a lot of my black men that come out of the prison system, there is no where for them to address that. But you know where we address that? In a federally qualified health center for free. Because it's what we're supposed to do.

And I know I'm over my time, but all I'm asking for is I'm asking the same thing that my colleagues asked for. Is we do need the correct support, but I need you also to pay attention to concordance as well. Here in Buffalo, New York, 38 percent African American in which 90 percent of them live within five ZIP codes. And if you do not have the healthcare professionals that represent those people, then you don't have connectivity.

(applause)

FDAG JENNIFER LEVY: So, Dr. Davis, I don't think I have to go to church this Sunday. Yeah, so I'm going to refer to her as Doctor Reverend.

DR. KENYANI DAVIS: Yeah.

AG LETITIA JAMES: So let me begin with Dr. Davis and talk about connectivity. So where

do we get the professionals who obviously can connect to these individuals? Individuals obviously who look like you and I.

DR. KENYANI DAVIS: Oh, thank you so much for that question. I was waiting for it.

AG LETITIA JAMES: There you go.

DR. KENYANI DAVIS: So medicine is my ministry --

AG LETITIA JAMES: Okay.

DR. KENYANI DAVIS: -- and I will say it all the time. If you seek, you will find. I am originally from Phoenix, Arizona, and people tell me all the time, well, it's really hard to attract physicians to stay here in Buffalo. That's crap. I am from a desert, and I don't know if you know, but I went through a whole blizzard and I'm still here. Had babies here and everything. If you're not looking --

AG LETITIA JAMES: You went from a desert to a snowstorm.

DR. KENYANI DAVIS: Listen, that's (indiscernible). But we have to be mindful and intentional. When we are intentional, it gets done. I had a -- in another hat that I have -- I'm trying to watch my time -- when we look at

our trainees, none of them look like me. Majority of the black positions that practice here in the U.S., if they don't come from an HBCU, they come from overseas.

When are we going to tell the little black girl that, hey, she can be a doctor, or hey, she can be an AG? That starts with our patients. I was somebody's patient once. So we have to be very intentional, and you have to put those in those plans. Not as an affirmative action thing because affirmative action didn't help little black women.

You have to be very intentional at the education level. How many black primary care physicians do we have? There's less than three percent in the nation for physicians in general. Here in Buffalo, when we look at our schools, how many of them are there? Who is mandating that we have to ensure that we have a workforce that's diverse?

I have a -- one that, you know, we trained at CHCB who wants to go into psychiatry, a wonderful, gifted African American female who applied to our program who still has to fight to get into our program. But yet, these people that

we're talking about come from her neighborhood and look like her.

AG LETITIA JAMES: Mmm.

DR. KENYANI DAVIS: There needs to be an intentional look. And I think what Chairperson April Baskin --

AG LETITIA JAMES: Baskin, right.

DR. KENYANI DAVIS: -- put together with the Department of Health and putting that center of equity in there is ensuring that we look at that, not because we want to check a box, because recruitment and retention are two totally different things. To truly look at it. Because if you can get it right in Buffalo, you can get it right anywhere.

In the next few years, our population will look exactly like the population in the country. So if you get it right here, you can get it right anywhere.

AG LETITIA JAMES: And is there -- when they leave your federally qualified center, is there a discharge plan for the individuals that, you know, that come to your facility?

DR. KENYANI DAVIS: A discharge plan in regards to from like the case workers or the --

AG LETITIA JAMES: Yes.

DR. KENYANI DAVIS: Well, we are a comprehensive center. So a lot of the patients that we see within our behavioral health team, we serve as their primary care physician. So we are probably one of the only places where I can see their notes.

AG LETITIA JAMES: And how do you -- you have a limited budget, a small budget --

DR. KENYANI DAVIS: Mm-hmm.

AG LETITIA JAMES: -- and yet you serve so many needs.

DR. KENYANI DAVIS: Mm-hmm.

AG LETITIA JAMES: How do you do that?

DR. KENYANI DAVIS: Listen, we serve an amazing God, and I have an amazing CEO in Dr. (Indiscernible) who the --

(applause)

DR. KENYANI DAVIS: -- who constantly says that the -- it's the spirit in which we work in the community. That's it. That's priority number one. So if we've got to rob Peter to pay Paul, we get it done.

AG LETITIA JAMES: So Dr. Davis, what legislation would you look at? What would you

change? What are some of the challenges on a state level?

DR. KENYANI DAVIS: Mm-hmm.

AG LETITIA JAMES: Are there any legal issues that you see? Any legal barriers that we could pursue? What are some of your recommendations, concrete recommendations?

DR. KENYANI DAVIS: Concrete. The very first thing that you have to fix is the reimbursement, the two service reimbursements. So like I said, I cannot see a patient in my behavioral health or my psychiatrist. We both can't see them at the same time, but they present --

AG LETITIA JAMES: So this is Medicaid reimbursement.

DR. KENYANI DAVIS: Right.

AG LETITIA JAMES: Okay.

DR. KENYANI DAVIS: Right. And that's as a federally qualified health center. I mean, we just -- we can't do it. It would be considered double dipping. So we really absolutely have to look into that. The second thing is some of these things that are non-billable --

AG LETITIA JAMES: Mm-hmm.

DR. KENYANI DAVIS: -- are truly the things that translates into good care. Everybody thinks, oh, they got to go see the doctor. Let me tell you something, I am not the person you need to see sometimes. But maybe you need to go see my caseworker or my case manager to help you navigate some of the types of --

AG LETITIA JAMES: Yeah.

DR. KENYANI DAVIS: -- stresses. But there's no 99213 or billable reimbursement code for that. So the -- we need a structure for our community based organizations to be able to build these insurance companies for the services that they do because they do good work.

(applause)

AG LETITIA JAMES: And then last question, Dr. Davis, you talked about 340(b), and that's something that I've been preoccupied with --

DR. KENYANI DAVIS: Yeah.

AG LETITIA JAMES: -- as the attorney general. So talk to me a little bit about 340(b) and some of those challenges.

DR. KENYANI DAVIS: I'd love to talk to

you about 340(b). 340(b) is, just to kind of level set --

AG LETITIA JAMES: Yeah.

DR. KENYANI DAVIS: -- is a program in which, if you can't afford your medications, we're able to give it at a discounted cost. And then whatever that surplus is, we're able to keep that money.

AG LETITIA JAMES: You're supposed to keep it.

DR. KENYANI DAVIS: We're supposed to keep it. Facts. So what we would do and what we do is we take that, and we allocate that money to support services that are non-billable.

AG LETITIA JAMES: Mm-hmm.

DR. KENYANI DAVIS: The care -- the case managers, the care coordinators. There's care coordination codes, case management codes, but you have to have two or more chronic diseases. You have to have this. There's no code for my 24-year-old African American male who has a history of bipolar who's been in and out of these hospitals who still just -- who needs counseling, who needs some care coordination because he doesn't understand the system.

There's no codes for that. So that's where the money for the 340(b) comes from so that I can get the support staff so that the right person can take care of the right person.

AG LETITIA JAMES: So we're looking at making sure that the -- those funds from the 340(b) program go to federally qualified centers for other --

DR. KENYANI DAVIS: Absolutely. To do the work.

AG LETITIA JAMES: Yeah, centers. Ms. Melfi, is that you? I'm sorry if I mispronounced it.

ERIN MELFI: Melfi.

AG LETITIA JAMES: Melfi. Thank you. Do you know if there is a bill pending in the assembly and/or the senate to include the creative arts because you were excluded?

ERIN MELFI: No. The only one that I'm aware of is that bill that just recently passed. In the language, like in the bill's language, creative arts therapists are included. However, it just recently came to my attention that there was a memo attached to that bill that just art therapists specifically took them out.

AG LETITIA JAMES: So they did an amendment, and they excluded the artist.

ERIN MELFI: Yes.

AG LETITIA JAMES: Okay. And with respect to the wages, when was the last time these professionals saw an increase? Or is it subject to a collective bargaining agreement?

ERIN MELFI: Yes. Oh, my goodness. This past summer because of the pandemic it had been on hold. So I think it was about -- and don't quote me on this, but I want to say four or five years.

AG LETITIA JAMES: And is there an effort to increase the number of individuals in your profession, or is it -- do -- are you -- do you continue to see challenges because of the low salary and because of the -- all the other issues that we mentioned?

ERIN MELFI: I can speak to -- so at BryLin Hospital, we do have an art therapy department, and that is unique to BryLin. And it's something that my colleague fought for --

AG LETITIA JAMES: Mmm.

ERIN MELFI: -- so that we would have our own space. I have advocated over the last

couple of years to expand the budget to allow more therapists to come in so we could have more groups, more individual sessions. I have -- that has not happened.

AG LETITIA JAMES: Do you primarily service young people, children?

ERIN MELFI: Everybody.

AG LETITIA JAMES: Everyone.

ERIN MELFI: I run groups with children as young as 5 or 6 up to, you know, all adults, you know, over 18 and up.

AG LETITIA JAMES: Thank you. Dr. Brooks, ECMC has been mentioned quite a bit in this hearing so far. What are your thoughts? I mean, obviously all of the closures and mergers has had an impact and you're at a capacity. And you've got patients in the hallway. You've got patients just about in every corner. And so what do you say to the witnesses who said that ECMC does not provide micro services for individuals who are struggling with alcoholism, drug addiction, and mental illness?

DR. VICTORIA BROOKS: Well, I think that, you know, ECMC is doing really good work at -- you know, my staff, you know, physicians,

nurses, social workers, aides, secure -- I mean, we come and work in the frontlines in a very busy and chaotic work environment every single day. We work in, you know, a safety net hospital where our doors are always open. We don't say no to anybody despite the fact that we do face challenges in, you know, making referrals, discharge planning, getting people to the resources that they need on the other side.

And we do the best we can. Everybody has staffing issues. It's not unique to us. It's certainly not unique to, you know, western New York. I mean, this is a pretty national problem at this point where --

AG LETITIA JAMES: Right.

DR. VICTORIA BROOKS: -- you know, the hospital leadership, and especially in behavioral health, it is constantly working to address this. As I mentioned, you know, our internal programs, we have, you know, worked extremely hard. I've, you know, been working in CPEP for 17 years. I've been the medical director for nine almost, and I have had a lot of support from the hospital in terms of networking and collaborating with, you know, the Departments of Mental Health in

Erie and Niagara Counties.

We have regular meetings with regional leadership from the Office of Mental Health, you know, attempting to address some of the children's issues that we face. And you know, we're constantly reaching out and making use of the resources that we know of and that we have available to use to do the best job that we can, you know, for the patients that we serve.

But I think there are these, you know, external challenges that we continue to face that are barriers both to access to care in the community. But also inasmuch as the community looks to CPEP in particular, and ECMC as, you know, kind of a leader or at the center of the conversation of what can we do to fix the community.

But that's a challenge in and of itself because, you know, we have our role to serve, and we'll continue to do the best we can in that. But once, you know, patients walk out of our doors, or even prior to coming in --

AG LETITIA JAMES: Yeah.

DR. VICTORIA BROOKS: -- there are so many other things that could be done, could be

improved upon, and we really need to rely on, you know, other parts of that service, you know, care within our community to be able to be part of that solution.

AG LETITIA JAMES: At our last hearing in the city, we heard a lot of outpatient providers about the need for more coordination between hospitals and outpatient providers. And the governor also mentioned this proposal in the State of the State. She suggested perhaps imposing a requirement on ERs, emergency rooms, to coordinate when making admission and discharge decisions. What are your thoughts on that?

DR. VICTORIA BROOKS: Well, I can tell you that we are constantly in contact. I mean, they're increasing regulatory requirements placed on our staff. There are constantly grants that we're being told about and being asked to participate in that include, you know, coordination of care, follow-up phone calls.

And I can tell you that, you know, part of our assessment process in and of itself requires, you know, contact. We're reaching out both to community providers if there are, you know, those connections already established, but

also, you know, make follow-up appointments and connecting them on the other side, you know, when they're being discharged. Additionally, we have access to PSYCKES, the Medicaid database.

AG LETITIA JAMES: Yeah.

DR. VICTORIA BROOKS: We have a requirement of our social work staff that they check that database for Medicaid patients --

AG LETITIA JAMES: Yeah.

DR. VICTORIA BROOKS: -- when they come in so that we have all of the information that we're incorporating into our assessments.

AG LETITIA JAMES: So you do use that web program PSYCKES.

DR. VICTORIA BROOKS: We do, yes. And one of the challenges, though, is when we make those phone calls and when we reach out to, you know, community providers, by the nature of CPEP being an emergency service --

AG LETITIA JAMES: Yeah.

DR. VICTORIA BROOKS: -- we -- often those calls go unanswered, you know, at night and on weekends or unreturned before we have to make a decision, clinically speaking, for you know, the care of that individual and what they

require.

AG LETITIA JAMES: So there's no -- none of these programs are available after 5 and on the weekends?

DR. VICTORIA BROOKS: Many of them are not.

AG LETITIA JAMES: Many of them.

DR. VICTORIA BROOKS: Or the phone calls aren't returned in a timely enough manner to be relevant to the assessment and needing to limit those delays in access to care, you know, from our decision-making process and, you know, wanting to be able to move people to where they need to be treatment-wise.

AG LETITIA JAMES: And the regulatory requirements, including the one being proposed by the governor in the state of New York, does it come with resources? Are they unfunded mandates?

DR. VICTORIA BROOKS: I can't speak to, you know, the details of all of that by my nature -- or by my role as, you know, a physician in the emergency room. I know that the hospital and behavioral health leadership is kind of staying on top of those mandates, and they work with like our social work leadership in kind of passing

those down and doing the things that need to happen. So I can't really speak to the details of reimbursement. I do know there's some grant funding that, you know, does kind of lead to the implementation of certain, you know --

AG LETITIA JAMES: Right. And this $1 billion that the governor's proposing, I believe in your testimony you indicated that if in fact ECMC were to get some of those funds, it would be used for capital improvements to improve your physical space?

DR. VICTORIA BROOKS: We could always improve the physical space as just -- I mean, I could talk for another two hours about suggestions on making that happen. But you know, all of that really requires collaboration with the hospital leadership and kind of decision-making that, you know, would have input from all of the members of our treatment team.

AG LETITIA JAMES: Thank you, Dr. Brooks. Any other questions from --

AAG MICHAEL REISMAN: Yeah. Just a quick question, Dr. Brooks, and thank you for being here today. We've heard a bit today about respite centers and recovery centers. And to Dr.

Davis' very good point that while there are people who do require inpatient psych services, there are a lot of people who don't. Are the -- are respite centers or recovery centers or these sorts of programs, are they on your radar at -- as a way to help people, to send people so that they don't need to basically wait around in the CPEP?

DR. VICTORIA BROOKS: Definitely. As I mentioned, it is -- you know, especially for someone in a crisis, it's traumatizing to come to, A, a hospital, an emergency room with a locked door behind you where, you know, locus of control is kind of removed. And there are a lot of reasons that diversion centers are ideal, both pre-hospital but also as an alternative to remaining in the CPEP unit or in a hospital for unnecessarily long periods of time because there is no alternative discharge opportunity. It has to do with, you know, both adult issues, but also issues in the children's system of care.

AAG MICHAEL REISMAN: Are there enough of those beds in Buffalo?

DR. VICTORIA BROOKS: For adults or children?

AAG MICHAEL REISMAN: For either.

DR. VICTORIA BROOKS: No. Probably not. Certainly there are challenges in the children's system of care that are much different. And you know, as I mentioned, we work with the Department of Social Services and with, you know, OMH to try to maximize those opportunities, but often that is a significant delay in discharge.

And additionally, on the adult side of things, you know, there are both problems with nursing care facilities, but also supportive housing for, you know, those with chronic mental illness. And you know, even just housing in general, shelter options in large part because many of those resources, while limited, also have the ability to say no.

And so we have to appeal to them for, you know, can I have a bed for -- A, do you have a bed for this person; and B, can this person in particular have that bed. And those are very different questions, and often the answer is no, and then we don't have another alternative.

AG LETITIA JAMES: Right. So Dr. Brooks and Dr. Davis, you know, we heard stories

about individuals who basically have left their child at your doorstep --

DR. VICTORIA BROOKS: Mm-hmm.

AG LETITIA JAMES: -- for psychiatric care because they have nowhere to turn. Were those -- was that an isolated story or two, or is that pretty much...

DR. VICTORIA BROOKS: Well, I can speak to my experience, which is that it is a frequent problem both for families and also for the hospital that feels kind of impotent at times to solve the problem for families. When, you know, a hospital serves a specific purpose, and if someone doesn't have acute symptoms that might reasonably be managed in an acute inpatient unit, then our CPEP, you know, we're often left to work with families to resolve many social issues.

Chronic ongoing behavioral, access to care on an ongoing basis in the community, things that Dr. Davis mentioned that usually patients that come in don't need me.

AG LETITIA JAMES: Right.

DR. VICTORIA BROOKS: More often they need kind of my support staff. And the hospital has brought in, you know, nurse case managers,

social work staff that are dedicated to work with just the children and adolescents that we serve. We have -- you know, Erie County DSS has dedicated a CPS worker full time embedded in CPEP because of the extent that her intervention is needed to be a liaison to DSS and CPEP.

AG LETITIA JAMES: But Dr. Brooks, is it behavioral or is it mental illness?

DR. VICTORIA BROOKS: Both, and those are --

AG LETITIA JAMES: And is the answer the Department of Social Services?

DR. VICTORIA BROOKS: No, but we need their input. We can't possibly solve those problems independently often without their input. And --

AG LETITIA JAMES: Right.

DR. VICTORIA BROOKS: -- not just, you know, Department of Social Services, but also, you know, the representatives from the county SPOA office and, you know, access to children's services in that direction. Because there's going to be the community based programs that --

AG LETITIA JAMES: Right.

DR. VICTORIA BROOKS: -- will help

support these children with more chronic ongoing behavioral disturbances that don't necessarily resolve or aren't addressed appropriately in an acute hospital setting.

AG LETITIA JAMES: Right.

DR. VICTORIA BROOKS: But obviously, they're, you know, to avoid the return to the hospital or the need for a higher level of care are really necessary in supporting discharge planning efforts.

AG LETITIA JAMES: Thank you. Dr. Davis?

DR. KENYANI DAVIS: Yeah. Sorry. They told me not to touch the mic and I did exactly what you told me not to. I would like to comment on that just from a different angle. And to answer your question, I don't know if Social Service is the right place for that because Social Services sometimes retraumatizes people.

And I get that that's where we kind of put stuff because we don't know where else to put it. But in the community that I serve, there are other, once again, good community based organizations that can handle some of this stuff. And when you say behavioral health or mental

health, sometimes you can't tease the two out. It's because when you have -- when you live in let's say dilapidated buildings, social determinates of health make up 80 percent of the totality of somebody's health.

AG LETITIA JAMES: Mm-hmm.

DR. KENYANI DAVIS: So if you live --

(applause)

DR. KENYANI DAVIS: -- in poor infrastructure that has, let's say, lead problems --

AG LETITIA JAMES: Right.

DR. KENYANI DAVIS: -- right, lead problems lead to impulsivity, lack of impulsivity control. Which then people get labeled as ADD or ADHD, and then they land into your criminal justice system. So how do you tease that out? Because that happened years ago, right? So of the "behavioral health issues" can be some mental health issues --

AG LETITIA JAMES: Right.

DR. KENYANI DAVIS: -- as well. And for me, I see the mothers who are bringing their kids in because of this, or they're at their wit's end. And who do I hook them up with? When

you have community organizations like SNUG --

AG LETITIA JAMES: Mm-hmm

DR. KENYANI DAVIS: -- right, and you have, you know, other people in the community who look like them who understand, a lot of times they're more impactful and more powerful than the stroke of my pen and my --

AG LETITIA JAMES: Right.

DR. KENYANI DAVIS: -- medication. So I don't think Social Services is the right place. Once again, I think it is creating the infrastructure for some of these grassroot organizations to do the work and look at this community from a community asset building instead of a community deficit.

AG LETITIA JAMES: Yeah. And --

(applause)

AG LETITIA JAMES: And lead paint is still an issue that we are still dealing with because the vast majority of our litigation against some of these -- regarding lead paint is in Buffalo.

DR. KENYANI DAVIS: We have a lot in common, don't we?

AG LETITIA JAMES: Yes, we do.

DR. KENYANI DAVIS: We do.

AG LETITIA JAMES: So, I want to thank you, Reverend Davis. I want to thank you, Dr. Brooks, and I want to thank you, Ms. Melfi, and I want to thank this panel. Thank you all.

(applause)

DR. KENYANI DAVIS: Thank you for the opportunity.

AAG STEPHANIE CALHOUN: Thank you, everyone. We will take a five-minute break for a mic check. Thank you.

(Break)

AAG STEPHANIE CALHOUN: -- you speak into the microphone so that the individuals on the livestream can hear you, as well as the live audience here. Our next panel consists of Sara Taylor --

AG LETITIA JAMES: Yes.

AAG STEPHANIE CALHOUN: Once again, our panel consists of Sara Taylor, Doug Hahn, Philip Vaillancourt, Denise Amato. You may each begin, and be mindful of the time. You may hear a beep at the conclusion of your allotted time.

SARA TAYLOR: Thank you for having me. My name is Sara Taylor from Rochester, New York,

and I am the founder of the BIPOC PEEEEEEK Parent Mental Health Project. There was nothing in my career and training as a social worker and non-profit administrator that would have prepared me for what it has been like navigating the mental health system for my child.

Not wanting to see my great-niece in the foster care system, our story began in 2009 when I was asked to care for my great-niece for 6 months, who was 11 months at that time, and born to a mother suffering from depression and homelessness.

My analogy and story of navigating the mental health system in New York state is a combination of TV shows and movies like a Lifetime movie, reality TV show, horror movie, Incredible Hulk, Jerry Springer Show, Color Purple, What Would You Do?, The Jeffersons, Medea Family Reunion, Judge Judy, Judge Maybelline, COPS, CSI Miami, Blackish, Young and the Restless, and even Roots.

If you would've asked me five years ago if my story and the realities of a black parent raising a child with a mental health condition was true I would say no. This experience has led

me to believe that we have systems of healthcare for children in this state. Children with medical conditions, white children with behavioral health conditions, and black and brown children with behavioral health conditions.

From 2018 to present, our journey has gone from six-month wait lists, more than 15 mental hygiene arrests, so many referrals for service that I can't keep up with, meeting after meeting, 15- to 24-hour waits in crisis emergency programs only to be sent away after hours of waiting and told it was behavioral, CSE meetings with unsafe child in psychiatric emergencies, two and a half years having my child in residential treatment, the levels of shame, blame, guilt unimaginable.

Having a system where there's no professional clinical staff of color that looks like us, programs that lack training, and culturally responsive care is heart-wrenching. Some of the non-strength-based things that I've heard in various settings within the mental health trauma-informed systems include I need to get my billable unit in by the end of the month, so I need to see your child. You're not like

other parents from this city.

Your daughter is not as bad as they told me she was. It looks like she's coming over here to cause trouble. Do you want to apply for SSI? You appear to be an overly aggressive parent. Some of our experiences navigating wait lists and crisis services from six weeks to six months, more than 10 --8 to 10 psychiatric emergency room visits as the largest university hospital systems when you're on the first floor of a medical pediatric emergency, and it makes the family's experience positive. A red carpet is rolled out to you.

You go one flight up to what I call the modern day Willow Brook where you wait for hours in filthy conditions with little sympathy in settings where no one introduces themselves to you or gives you eye contact. This is heart-wrenching. Agreeing to have my child take medication to get out of crisis, fast-forward, she gained 60 pounds.

If I would've been educated more, 2020 two days before Christmas, admitting my child to a children's psychiatric hospital 60 miles away with her matted hair, I asked the staff is there

anyone that can do ethnic hair. They say what do you mean. Always asking is there a therapist of color, told we don't have any trained. Calling for 911 emergencies, they manhandle her.

As a black parent living this three-year journey in and out of emergencies, multiple mental hygiene arrests, various levels of residential outpatient services has given me an up-close and personal perspective of the current children's mental health crisis.

We have deep-rooted system in equities negatively impacting black and brown children, and we can't blame it all on COVID. We have the data around disparities. In October of 2020, the Surgo Foundation and Mental Health of America cited 13 cities impacted by the negative impact of mental health and high poverty census track identifying Rochester, Buffalo, and Syracuse as triple threats. Triple threats.

We know what the statistics are telling us about black suicide rates among our youth. And fresh off the press, the Satcher Health Leadership Institute at Morehouse School of Medicine just in September released the first of a kind report highlighting the economic burden of

mental health and equities in the United States found that 177,000 lives were lost and approximately $280 billion could have been saved.

So (audio skip) community level non-clinical culturally responsive care in high poverty census tracks. Our folks don't always need hospitals and emergency (audio skip). No one is talking about mental health and equities, and as we're not addressing it as a community level, non-clinical culturally responsive care, and high poverty census tracks. Our folks don't always need hospitals and emergencies.

It's not okay to keep funding the same programs that are not working with evidence-based models that are not culturally responsive. I'm tired of the check-the-box parent advisory boards that are fake. We got parent advisors in all the OMH field offices, but when the new act RFPs were rolled out, not one parent was consulted or youth stopped using us.

We are experts. We need to address things from an equitable lens. We're not talking to high Medicaid populations of black and brown parents that will never show up at clinics. What are we doing about equity and these fake check-

the-box DEI initiatives? We need to be intentional with measurable outcomes with the data from the Office of Mental Health regarding Children's Behavioral Services and that equitable lens and the disparities and inequities.

Our children are criminalized at levels. How many youth, black youth, have left our residential facilities and went to the Juvenile Justice Center? I can tell you right now my child's waiting to come home, waiting to come home after two and a half years.

I just had a meeting yesterday. There's no school for her right now. With the staffing issues, she's starting to regress. We want her home. There's staffing issues in the day treatment programs. What are we going to do about the equity and the injustices done to our black and brown children? Yes, in deep-rooted systemic issues even in the mental health system here in New York state.

(applause)

SARA TAYLOR: Thank you.

DOUG HAHN: Hello. My name is Douglas Hahn, and I am a youth peer advocate with the Mental Health Advocates of Western New York. I

also happen to be someone who has lived through the mental health system both as a child and as an adult. Over the course of my life, I first got hospitalized when I was at the age of 10. I am now 26, and I've been hospitalized an additional six times. And I've also worked in those same facilities that I have been hospitalized in.

Over the years I've noticed a really encouraging increase of conversation around mental health. A larger acceptance from the youth that having these facilities and going to them, it's okay. That, unfortunately, has been coupled with a decrease in beds, a decrease in funding and programming in the facilities, and overall just huge staff turnover rates.

This has led to a problem where youth who need these services for safety reasons, for, you know, help that they want, can't access them. Then they do access them, it is you get in, they check your medication, you get out. There is just such a backlog that it has created a sense of almost despair with the youth I work with individually.

You know, I've had a client that I

worked with who had stayed in a short-term hospitalization for about two weeks before they were then transferred to a long-term hospitalization. They were only at that long-term hospitalization for a month. I've been at a short-term facility for a month just waiting to get into a long-term facility.

The fact that they were only allowed to stay there for a month because of -- it was during the time of COVID, so there were policies moving them through. They didn't get the services they needed. They were struggling severely to a place that should have been their last resort to get those needed services was taken away from them because of that.

I, myself, have attempted suicide many times over the course of my life. And it was in one of my hospital stays that I was able to find a reason to keep living. It is what put me on the course of my path where I am now. I shudder at the thought of if I was now going through the same exact struggles but being put in the same hospitals. It would be a completely different experience with completely different outcomes.

The programming's not there, the staff

-- just -- it's very hard to have an accommodating and welcoming environment when the most experienced staff has only been there for four months. How can they provide the best services possible?

So again, to just -- and it really pains me because, you know, I work now with youth who have been in similar situations. And you know, before when I was younger, 10 years, you know, 15 years ago, I would've happily told them please go here, go to this hospital, utilize these services. I know the people there. They're going to do great work for you. I can't say that anymore.

AG LETITIA JAMES: Mmm.

DOUG HAHN: And you know, I have to do my best to try and help them in these crises, but we are failing the youth in a spectacular way when we are saying you need to go to a hospital, you can't be safe, and that hospital environment is an added trigger, and not safe for that individual. That's all I'll say.

(applause)

AG LETITIA JAMES: Thank you.

PHILIP VAILLANCOURT: My name's Phil

Vaillancourt. It is an honor to be here to speak on a matter I'm passionate about, mental illness.

AG LETITIA JAMES: Mr. Vaillancourt, could you move the microphone a little just closer to you?

PHILIP VAILLANCOURT: Sorry.

AG LETITIA JAMES: Thank you.

PHILIP VAILLANCOURT: So many families like mine are struggling to help -- to get help and the resources for a loved one who suffers from mental illness. My story is consistent to those around me. We have a lack of immediate placement facilities in our area, and we have a lack of staffing and staffing challenges to combat mental illness.

My child was discharged from the psychiatric center last summer, and shortly after discharge their mental health declined to a point where I needed crisis services and police assistance on several occasions where they were transported to ECMC's CPEP. On each visit, my child was evaluated and discharged as they did not meet criteria to be admitted.

Upon coming home, my child's behavior worsened. On one occasion, my child was running

in the road trying to get hit by oncoming traffic. Crisis services were called and police were dispatched where my child charged after the responding officer who was on the scene to de-escalate. My child was brought back to ECMC CPEP. After another evaluation, I was called to pick up my child.

Another time, my child was attacking me while I was driving, and I needed police assistance. When the officers arrived, it took four officers to remove my child from the vehicle and transport back to ECMC CPEP. Again, my child did not meet criteria to be admitted. After this final time, I realized my child needed significant help.

I would think that if someone was a harm to themselves or others that would meet criteria to be admitted. I was mistaken. My child's behavior was at a level I was concerned about their well-being and the safety of my family members and the community. I was asked to pick up my child once again, and I refused. I believe this was in the best interest of my community and family.

The hospital felt that I was neglecting

my child and therefore reported my case to Child Protective Services. No, I was not -- or no, I was protecting my child from harming themselves and my other children. As a parent, knowing that I did not pick up my child from when ECMC requested a pick-up, there was a risk of Child Protective Services involvement and the scare of removal of my other children from my home is a concern of mine.

When Child Protective Services was involved, my neglect case was unfounded, and that is when I finally started receiving the help I needed. No family should have to go through the measures I took such as calling the police seven times and Child Protective Services in order to get a loved one mental help. It should not have taken that long for my child to get the resources they needed. Thank you.

AG LETITIA JAMES: Thank you.

(applause)

DENISE AMATO: Good afternoon, Attorney General James --

AG LETITIA JAMES: Good afternoon.

DENISE AMATO: -- and staff. To all mental health advocates, providers, families and

everyone indirectly or directly involved with the mental health of our Buffalo community. My name is Denise Amato, and I'm the proud mother of a 20-year-old son who, for the past four years, has suffered with mental health having been diagnosed with bipolar disorder 2.

Let me prefix this by saying that never in my life would I have ever predicted the horrible challenges that our citizens must deal with when suffering from mental health disorders. My son Alexander was a happy, polite, very outgoing child who made friends and was always an honor roll student all through school.

He played sports. Sometimes even won rookie of he year, was on the student council, and he performed in plays and musicals. But he started suffering from depression and anxiety with his high expectations of himself. And it was also, I assume, at the height of his adolescent growth spurt. So I do believe hormones have a lot to do with young men and bipolar disorder.

Our first real experience with crisis came when he decided that he was too overburdened with his extensive school and thought attempted

suicide was the only answer. That was four years ago. Since his first initial hospitalization in the youth ward of ECMC, that is when they did the diagnosis of bipolar disorder 2. It has been a very disheartening experience to say the least while trying different doctors, different cocktails of medications, always trial and error.

The challenges of communication with doctors, calling their office and never getting return phone calls back, also dealing with their insurance problems. Some don't take GEER insurance. Some charge $100 for a visit. Who can afford that? Who can anybody afford $100 monthly visit?

So with those severe lack of resources that we have available, oftentimes our only course of action was to drive him or have the ambulance take him to the emergency department of either ECMC or Niagara Falls Memorial. Unfortunately, I feel that the shortages of psychologists and psychiatrists are affecting the problems that we are facing.

A lot of times you would call an office and they'd say, oh, we're sorry, it'll be two to three months for an initial consultation because

we have an upsurge of patients because of COVID. That's not acceptable. What do you do if your son is escalating his behavior? Two to three months. It could cause harm. It could cause suicide.

So I just want to just read this part, but they don't have time because they're overburdened. So there's no follow-up. With HIPAA, if a person is 18 years old or over, he might feel incapacitated in not being able to express themselves, but then you -- they won't talk to the parents. And the parents are the frontline of mental health.

We are the ones that deal with our family member day in and day out. We know what the signs are, but we aren't medical doctors or psychiatrists that can actually administer medicine. And we do need to try to attempt a more wholistic approach as well. Because I do often think that we are over-medicating our loved ones.

(applause)

DENISE AMATO: I already addressed about the health insurance, and I do believe that is a huge problem. So basically because of the

challenges of reaching doctors, we cannot become proactive, and I truly believe that proactive is where we need to be.

Just a quick little story. A couple of summers ago, we took a road trip out to Rhode Island to visit my family. But my son had started being manic, and the mania can be positive at first, but it ends up becoming a non-sleep thing. And anyone in this room or elsewhere who goes without sleep for more than a day, their behavior will become agitated, aggressive, negative. It doesn't matter.

We are humans. We need our basic water, food, shelter, and sleep. So what happened was, when I saw this happening, I called our mental health provider back here in Buffalo, and I pled to have them prescribe us something for him to sleep. Because I knew that we could hit it head-on if he could only sleep the night. Do you know that they never, ever returned my phone call?

I was in tears. We had to cut the trip short and come back and go to an emergency room. So you can only imagine the frustration that I felt, and I would never, ever wish that on any

parent. Therefore, I am here today to plead to you our attorney general, and to all leaders in western New York, that we do have a very urgent and extreme need for mental health assistance. Our citizens deserve much better quality of life than we are providing at this time.

We need more providers, more comprehensive care that would prevent hospitalization, and would alleviate the volume at our two psychiatric emergency departments, which are ECMS and Niagara Falls Memorial, and I do believe BryLin.

I guess I'm out of time, but I do want to say that my son spent almost a month at the ECMC psychiatric unit there. And while he was in CPEP, he had to sleep on the floor for four nights. They had a computer glitch. They weren't fed lunch one day. They stole his shoes, stole his shirt. He was assaulted by someone on the floor.

I actually would leave crying being so depressed that I did make an appointment and met with the CEO -- COO Andrew Davis and also the VP of mental health just to address my concerns. Of course, again, it's a staffing issue. They don't

have enough beds. They can't handle the volume because everyone from the holding center to homeless to all the areas surrounding come to the ECMC.

AG LETITIA JAMES: Yes.

DENISE AMATO: So, I just want to say in conclusion, I am asking all of us here to work together to urge our leaders to create more comprehensive centers because our family members deserve good quality of life. We must advocate for those who do not have a voice at times, or if they are suffering too much to ask for help.

Our community's future also depends on it. I will sincerely keep the hope alive for all of us here in western New York impacted by this unexplainable and ever-increasing need for proactive and respectful mental healthcare. Thank you very much for your time today and for allowing me to share our story.

AG LETITIA JAMES: Thank you, Ms. Amato. Let me begin with Ms. Taylor. Ms. Taylor, Rochester, Buffalo, and Syracuse high census tracks -- high poverty census tracks. You talked a lot about equity and systemic injustices, so my -- and disparities. My

question to you is what are your recommendations and thoughts on addressing some of the inequities? And can we do it through an RFP if at all possible?

SARA TAYLOR: Absolutely. To give you an example of disparities, we know that culturally we have to approach mental health in a different way and engage. And when we look at -- to give you an example, our project started to train more family peer advocates of color. Why was that not a priority? You look at who's being served in the mental health system, particularly upstate New York.

AG LETITIA JAMES: Yeah.

SARA TAYLOR: And when you look at the demographic of who are family peer advocates, don't tell me you can't find us. Are you being intentional about engaging families and helping them in a preventive manner?

We also know after the Buffalo massacre that OMH was very responsive at funding untraditional services, like healing circles, restorative practices. How come that can't be the norm? Everything is not going to fit into -- when you're talking about diverse ethnic

populations, everything is not going to fit into a Medicaid billable check-off. It's not. It's not. So we need to become intentional. It's frustrating. I heard Dr. Davis say it.

AG LETITIA JAMES: Yeah.

SARA TAYLOR: We've got to stop saying we can't recruit. We have these residential facilities that have minority staff working at the front end. Who is developing them to advance?

AG LETITIA JAMES: Ms. Taylor, can you name some models that are out there?

SARA TAYLOR: Absolutely. One model in Pittsburgh that is called Steel Smiling.

AG LETITIA JAMES: Steel Smiling?

SARA TAYLOR: Steel, like the Steelers. Steel Smiling --

AG LETITIA JAMES: Okay.

SARA TAYLOR: -- we're hoping to bring to this community.

AG LETITIA JAMES: Okay.

SARA TAYLOR: They go into Alleghany County and black communities, recruit cohorts of residents, give them therapy, address the racial trauma, and then they train them to be community

mental health workers. So we got healthcare outcomes, and we have workforce outcomes. That is the model we're hoping to bring and pilot in this community. Trusted voices right in the neighborhood. I can tell you after Daniel Prude, what happened in Rochester, we had many support groups with parents in Rochester and Buffalo that said my child is cutting themselves --

AG LETITIA JAMES: Mmm.

SARA TAYLOR: -- but I would never call the police right now. So we have so many families suffering silently that would never, for whatever reason, show up at a clinic door. But how come we're not meeting them at the rec center, the barber shops, the ministries?

(applause)

SARA TAYLOR: Doing something different and innovative and allowing parents. We got to stop having these advisory boards. We have great peer programs with parents, but let's be real. When it comes to our black and brown communities, we're not showing up in Albany.

AG LETITIA JAMES: Mmm.

SARA TAYLOR: Okay? So what do we need to do to go into the neighborhood in safe spaces

and places and meet them to hear our issues from us that look like us? Empathetic. That -- it can be done, and we have to be willing to do something different. And one of the things that we know, evidence-based models are important. We know that. But when we look at who's doing the research, when we look -- that is designing the evidence-based models, they don't look like me.

WOMAN: Mm-hmm.

SARA TAYLOR: They don't understand it from a cultural lens. So are we going to invest in mental health and research in models to help us develop models that work for our people? It's time. We have an opportunity, particularly after the massacre here.

AG LETITIA JAMES: Yeah.

SARA TAYLOR: Families are hurting. They're not necessarily showing up at clinics. They may want something different, and it's okay. But are we heightening those models and investing in them?

AG LETITIA JAMES: Thank you, Ms. Taylor.

SARA TAYLOR: Thank you.

(applause)

AG LETITIA JAMES: Mr. Hahn, what put you on the road to recovery? How did you...

DOUG HAHN: This way. So for me personally -- is it good enough? How about now?

AG LETITIA JAMES: Yeah, that's fine.

DOUG HAHN: Yeah, okay. So for me, a large part of my trauma was from having trust broken from an adult. So a large part of my journey was never really opening up to an adult, so no parents, no counselors, no social workers. None of them were able to really help me.

It was at one of my hospital stays, however, that I met someone that does what I do now, a youth peer advocate. They were a lot closer to me in age. I think at the time they were only like six years older than me.

AG LETITIA JAMES: Mmm.

DOUG HAHN: Their story was shockingly similar to mine. And the thing that really did it for me was they went through a lot of the same things I did, but they're an adult now. They have a job. They're living their life. That was something back then that I thought I was going to be dead by the age of 17. I would never make it to adulthood.

AG LETITIA JAMES: Mmm.

DOUG HAHN: So seeing somebody very similar to me make it past that, that completely changed the trajectory of my life.

AG LETITIA JAMES: And so where do you refer young people to today? A young person engages in self-mutilation, where do you refer them?

DOUG HAHN: I'm sorry. I didn't quite hear that.

AG LETITIA JAMES: If an individual engages in self-harm, where do you refer them? What do you -- how do you counsel them?

DOUG HAHN: You do the best you can, I guess. I mean, I have to try and give them as much support and empathy as I can. But at the end of the day, and you know that's kind of why I wanted to talk about the hospitals is --

AG LETITIA JAMES: Yeah.

DOUG HAHN: -- if it is that severe where their safety is in play, that's where they have to be. I mean, I myself, like I mentioned was hospitalized seven times. Each one of those times was in a very severe situation where had I not been there, who knows, right?

AG LETITIA JAMES: Right.

DOUG HAHN: So I really want to emphasize, you know, we want those proactive treatments that everybody else has been talking about. But the hard reality at the end of the day is the hospitals are needed, and they definitely need to be improved vastly.

AG LETITIA JAMES: Mr. Vaillancourt, did I say that correctly?

PHILIP VAILLANCOURT: Yes.

AG LETITIA JAMES: How is your son today?

PHILIP VAILLANCOURT: My child's currently at an RTF getting more --

AG LETITIA JAMES: And -- go ahead.

PHILIP VAILLANCOURT: -- more help, but their stay at ECMC was about four months before they were finally transferred to an RTF.

AG LETITIA JAMES: But you only got assistance when you basically surrendered your child at the hospital, correct?

PHILIP VAILLANCOURT: Correct.

AG LETITIA JAMES: And it shouldn't have -- parents should not have to surrender their children and/or abandon their children at

the doors of a hospital.

PHILIP VAILLANCOURT: No. The other part that she -- my child was discharged from the psychiatric center in West Seneca, they -- ECMC felt that there was going to be struggles with the transition home, which I was aware of that. But to the level it was at, it was not --

AG LETITIA JAMES: Right.

PHILIP VAILLANCOURT: -- bearable for my -- rest of my family. And for the safety of all of us, to me she needed more help.

AG LETITIA JAMES: Yeah. I want to thank you for your testimony. And Ms. Amato, what are your recommendations with regards to changing the system?

DENISE AMATO: I guess it's complicated, but number one I would improve on the health insurances. I would make it completely affordable and that providers cannot refuse any insurance. That is so big. The insurance that we use is out-of-state, and you would not believe how many providers will not accept it.

AG LETITIA JAMES: Right.

DENISE AMATO: And that's his father's

insurance, so there's nothing much, you know, we can do about that.

(audio skip)

DENISE AMATO: -- and they could have access on weekends and holidays.

AG LETITIA JAMES: Okay. And do you support peer advocates? And that's a question for Ms. Amato and Mr. Vaillancourt. Because the other two are primarily advocating for peer advocates who are culturally sensitive and who believe in equity. Do you -- and in addition to more comprehensive centers, do both of you support peer advocates?

DENISE AMATO: As far as me, myself, I definitely would. Even considered to become an adult peer advocate, and I highly believe that they are a very valuable service. And they would give a little bit more of a humanitarian touch to people dealing with behavioral issues compared to a psychiatric or nurse practitioner who sits at her computer and can't even give the patient 20 minutes of their time and with eye contact. They are just sitting there dut, dadut, dadut, dadut, dadut.

(applause)

DENISE AMATO: These people are human beings with feelings. It doesn't matter what background you came from. People -- like they said, one out of five in society will deal with mental health issues. So we need to make it so that this is like mind, body, soul. You go to your doctor for testing. People should also be able to be treated for the problems that they're feeling emotionally, and we're not doing that. We are very short of our goal.

AG LETITIA JAMES: Mr. Vaillancourt, do you want say something?

PHILIP VAILLANCOURT: No, I've already (indiscernible).

AG LETITIA JAMES: Okay. Thank you. I appreciate your testimony. Thank you all.

SARA TAYLOR: Thank you.

AG LETITIA JAMES: Thank you.

(applause)

AAG STEPHANIE CALHOUN: Good afternoon. I'd like to get our next panel taken care of here. Melinda Dubois, Mental Health Advocates of Western New York, Chacku Mathai, member of New York State Behavioral Health Services Advisory Council. Just please be mindful of the clock,

but as well as speak into the microphone thank you.

MELINDA DUBOIS: Thank you.

WOMAN: You may begin.

MELINDA DUBOIS: Okay. Thank you, Attorney General, for holding this public hearing. My name is Melinda Dubois, and I am the Executive Director of the Mental Health Advocates of Western New York. And I'm also the Chair of the Anti-Stigma Coalition.

Today I'd like to speak about four specific issues, children's services, peer support, crisis care, and the importance of prevention. At MHA, we help families negotiate the children's system of care. Parents consistently say it is confusing and inadequate.

At times, families are forced to make incredibly difficult decisions, and you heard about some of those decisions in the previous panel. We work with families who have taken out second mortgages to get their child the care they need. Parents who refuse to allow their child to be discharged to their home due to the fear that they have that their other children will be hurt or traumatized. Sometimes CPS is called on these

parents.

We have families who have had to quit their jobs to care for their child. Our family peer advocates work with parents who are frustrated, feel defeated, and are desperate for help. There are not enough residential treatment centers. The system for accessing these services is cumbersome and complicated, and our children are suffering.

Our court-appointed special advocates work with abused and neglected children who consistently fall through the cracks. They are languishing within systems that are not adequate to meet their special needs. At MHA, we frequently hear complaints about the care received at CPEP.

We know that CPEP is understaffed and under-resourced. Staff are working under very difficult conditions, and both staff and patients are feeling traumatized. CPEP reform needs to be a priority. We need a CPEP where our most vulnerable citizens are wrapped around with love and compassion, where their needs are met, and they are treated with dignity, where adequate follow-up care is available, where visits to CPEP

are rare because needs are met in the community.

When that happens, we will be on our way to supporting our vulnerable citizens. And until that happens, our services will come up short. At MHA, our staff are peers. While New York State recognizes the power of peers in the workforce, the overly restrictive regulations required by OMH make it difficult for smaller peer agencies like MHA to continue to provide this essential care.

It is time for us to recognize that alternative methods of care can be just as effective as traditional models. Community mental health workers, peers, and alternative treatments are essential to the future of mental healthcare.

This is a community-wide problem and needs to be addressed in every part of the community in schools, in workplaces, and on the streets. And finally, prevention is key. At MHA, we provide programs in schools for children as young as four years old.

AG LETITIA JAMES: Mmm.

MELINDA DUBOIS: Our youth peer advocates like Doug Hahn are in middle school and

high schools. We provide mental health first aid training. Our prevention programs should be funded and in every school. In New York state, mental health education is a requirement, but we know that many underfunded, understaffed schools are checking the box rather than vigorously incorporating mental health into every aspect of their teaching. It is as important as math and science.

In closing, changing the system will require a coordinated effort. It must, must include consumers and peers in the solution, and will only succeed if mental health is addressed at every level. Prevention, early intervention, addressing stigma, ensuring all have access to care, and finally, treating individuals and families in crisis with compassion, dignity and love are essential to the solution. When these changes occur, we will be on the right path to addressing the mental health needs of our community.

AG LETITIA JAMES: Thank you.

MELINDA DUBOIS: Thank you very much.

(applause)

CHACKU MATHAI: Thank you very much --

AG LETITIA JAMES: Thank you.

CHACKU MATHAI: -- for having all of us here --

AG LETITIA JAMES: Thank you.

CHACKU MATHAI: -- and for taking the time to organize the hearing, Attorney General.

AG LETITIA JAMES: Thank you.

CHACKU MATHAI: You know, I've submitted written testimony. My head's spinning a little bit after listening to all the great comments from everyone. I applaud all the comments. You know, I think the best way for me to proceed is to start with probably just a couple of main points.

One is that, you know, I myself am here as a person with lived experience. In my family, we emigrated here from -- I'm born in Kuwait. My family's from India. We emigrated in the 70s to New York City, and then, you know, we've been a resident in Rochester, New York. We moved to New York City first, then Rochester. I was in Albany, back to Washington Heights, and now back to Rochester.

We moved back to Rochester just before the video of Daniel Prude being killed was

revealed, you know? And we were in the streets immediately ourselves. And I say this because as a person who's -- my family, you know, saw me struggling as a very young child dealing with xenophobia and racism in the community with the bullying and the assaults and the -- you know, all the rejection, you know, of, you know, seeing students and teachers that didn't look like me --

AG LETITIA JAMES: Right.

CHACKU MATHAI: -- or sound like me or talk like me. So I guess when we -- when they -- when I started to, you know, flip tables, and struggle, and think my parents were trying to kill me, and not trust anyone around me, and lose the sense of safety wherever I was, you know, my parents didn't know what to do.

AG LETITIA JAMES: Mmm.

CHACKU MATHAI: They certainly didn't call 911. You know, then when police came, they didn't want to try to tell them where I was, you know? They were trying to keep me safe. So there was a real quandary we were in. Who do we turn to, you know?

And so when I -- after a suicide attempt at the age of 15, I was also using drugs

and, you know, I had a number of issues, you know? Substance use issues, mental health issues. My father was in -- I was in the hospital and my father went to a friend of his in church. And he just said, look, my son's in the hospital, he tried to kill himself, he's on drugs, he's on the street. I don't know what to do, you know?

And this man said something that changed our family's life, you know? He said to my father me too, my son's also struggling. I just took a medical leave he said, and we just renovated an old horse barn across from the high school, you know, the high school in Rochester. And we've put some pool tables in it, some couches, and we gave it to the young people to support each other. Maybe your son will go there.

AG LETITIA JAMES: Mmm.

CHACKU MATHAI: And my son said, yeah, I'll give it a shot, you know? So he went with me to this place, and I looked through the window, and I could see that they looked like the same people that had been fighting me and bullying me all the time, you know? So I said

here we go again.

I opened the door, and this skinhead -- you know, I looked very different. I had long hair that I didn't let anybody touch, you know, and I was a 100 pounds soaking wet maybe. And I had a -- you know, I always had a scowl on my face. And this guy who was playing pool, he was a skinhead. He looked like -- exactly like whoever would protect me. He looked at me with these warm loving eyes and just said, hey, you want come over and play some pool.

It somehow disarmed me. I don't know. It was like a magnet. I just walked right up to him, you know, and said sure. And he even made a joke about my hair, you know, and that -- usually those are fighting words, you know? Instead I said, yeah, maybe I will get a haircut one day. You know, that kind of thing.

And I've been that -- I was in that place ever since. That peer support that showed up in that environment, the advocacy opportunities, Representative Louise Slaughter was one of the first people to ask me what do you think we need to do, you know? And I was on panels like this ever since for the last 37 years

or so I think now.

AG LETITIA JAMES: Mmm.

CHACKU MATHAI: And we've been saying the same thing. Stop forcing us into care into the types of services that we don't want.

(applause)

CHACKU MATHAI: And seeing the people that are black and brown as solutions in your community, not as the people who are dangerous, you know? Look for our leadership and turn to us. So I have some other answers, but I know my time is up because I've really appreciated everyone's comments.

AG LETITIA JAMES: I can actually listen to you longer, so -- I really want to thank you both for your testimony. So Ms. Dubois?

MELINDA DUBOIS: Dubois.

AG LETITIA JAMES: Dubois, alternate methods of care and alternatives to treatment, give me -- talk a little bit about that.

MELINDA DUBOIS: Sure. I think you might've heard earlier Sara Taylor talking a little bit about some alternative methods of treatment. What we've found is that really peer

support has so much impact as we've heard from other panelists because they've been through this experience. They know what it's like for individuals.

They have such power and influence over individuals who are struggling. In New York state, in order to become a peer, you go through a lot of training, and you can get your provisional peer credentials, and then you have to go through more training.

AG LETITIA JAMES: Right.

MELINDA DUBOIS: It's extensive training, which I love, and I approve, except for it's again onerous, and sometimes not billable in the ways that you would think it should be. And so when we can find alternative methods of care like peer support, like community mental health workers. A wonderful example of that is what Buffalo Urban League's Project Hope did during COVID and then did after 5/14 and then after the blizzard.

They knocked on doors, went to people's homes, and asked them if they needed help. That was an effective model. We expect people to come to our brick and mortar clinics, to our

hospitals, to our locations. They system is made for the professionals. It's not make for the individuals that are seeking help.

(applause)

AG LETITIA JAMES: Yeah. So Mr. Mathai, what's interesting is this hearing has been primarily focused on support for peers. We've talked a little bit about beds to a certain extent, but it's more about peer support and about making sure that there is more community-based organizations. So where do you fall in the spectrum? Is it more peer support? Is it less institutionalization, or...

CHACKU MATHAI: Yeah. So I've been pretty consistent in our advocacy around needing to scale up the community supports --

AG LETITIA JAMES: Okay.

CHACKU MATHAI: -- and all of the alternative -- I have been an advocate for all of the alternatives, my family and I, ever since because the tying up the dollars in institutional care -- and we were rejecting all of that institutional care. It wasn't what was going to work for us. We were trying to get out of that type of a system --

AG LETITIA JAMES: Right.

CHACKU MATHAI: -- and approach. But to actually engage us and support us in the community, there's a lot of great models out there now. I mean, so everything from the crisis support that we could offer. There's inset models that -- in Westchester that we could expand. That supports the same group of people that are normally put into Kendra's Law, petitions.

AG LETITIA JAMES: Yeah.

CHACKU MATHAI: So 70 percent of that population was being engaged successfully. There's cahoots model for police and we're trying to propose that under Daniel's Law.

AG LETITIA JAMES: Right.

CHACKU MATHAI: There's a model where that's combining peer and EMT support in that regard of crisis gauging. And everything from employment to housing to all the social determinants that people were already speaking to need to be intersected with those supports that we're talking about in the community, and to have them be part of -- just part and parcel of how some -- somebody operates.

AG LETITIA JAMES: Right.

CHACKU MATHAI: Another one I want to mention is self-directed care, and this is where somebody would actually receive the funds that would normally be given to a provider. And instead, that person now --

AG LETITIA JAMES: Right.

CHACKU MATHAI: -- with a broker gets to choose what kind of supports they want. So if I don't have a person of color as a therapist --

AG LETITIA JAMES: Right.

CHACKU MATHAI: -- that's funded in the public system, I can go get that in the private system with those dollars. If I want a particular yoga class or something else, which by the way my family has -- I hated yoga growing up because they pushed it so much. You know what I mean? But it's part of our healing process. Ayurveda is part of our healing. So these are the kinds of things that could get funded and supported more effectively.

AG LETITIA JAMES: Yeah, and I support more yoga in our schools, particularly in the elementary schools.

CHACKU MATHAI: That's right.

AG LETITIA JAMES: So I thank you all for your testimony. I appreciate you.

CHACKU MATHAI: Thank you.

(applause)

AAG STEPHANIE CALHOUN: Our next panel is Michele Brooks, former Executive Director of Buffalo National Alliance on Mental Illness, Frank Cerny, the Rural Outreach Center, Shannon Higbee, CEO of Recovery Options Inc. Just a reminder to speak into the microphone. We have a hard stop at four minutes for each of your discussions, and I will flash you towards the end. Thank you.

SHANNON HIGBEE: Good afternoon. Thank you for those of you who have stuck with us all afternoon here. I'm Shannon Higbee, and I serve as the CEO of Recovery Options, a peer-run community mental health organization serving western New York and the Finger Lakes region.

Today I speak on behalf of three additional western New York agencies, Restoration Society, Community Missions, and Liberty Resources. We are all members of the New York Association of Psychiatric Rehabilitation Services, a statewide partnership of people who

use and/or provide community mental health services under the leadership of its CEO Harvey Rosenthal.

Together we bring nearly 250 years of collective experience in providing high quality, peer-focused community mental health services. We appreciate the attorney general's interest in feedback about the barriers that exist in accessing adequate mental health treatment in western New York, especially as regards to crisis services for children and adults.

We acknowledge that New York State has made a number of significant investments in the mental health crisis continuum and mental health services as a whole. However, we know that every day children, families, and adults continue to spend hours or days in waiting rooms for crisis services and supports that ultimately often fail to fully address the needs of the individual when proven models for voluntary community alternatives do exist.

We do not believe that a blanket solution of just increasing inpatient hospital beds is the appropriate solution to address the complex needs of New Yorkers experiencing mental

health crises. Our agencies offer peer-operated services addressing a range of needs, including services for children and families, housing support, advocacy, employment, crisis and wellness planning, community engagement, and homelessness utilizing evidence-based models.

We're especially adept at providing a continuum of crisis services that are getting considerable attention across the state. For example, Recovery Options is poised to open the first of its kind 24-hour Kirsten Vincent Respite and Recovery Center in the underserved Fruit Belt neighborhood in Buffalo, New York in early 2023 that combines multiple levels of crisis and community services and supports in one facility through collaboration with Spectrum Health and Human Services and Western New York Independent Living.

Using proven models of hospital diversion, this center and others like it offer a voluntary recovery-focused alternative to inpatient hospital care that promotes ongoing community independence for its guests while offering a cost-effective and trauma-informed response. We have also launched a peer workforce

development project in the Fruit Belt to support staffing this model to keep our promise to the community to staff from the community for the community.

However, a lack of community and first responder understanding of available hospital alternatives has created a systemic underutilization of peer-operated services where hospital emergency rooms have become a default response to all mental health crisis regardless of available alternatives.

This cycle can only be broken through developing, fully funding, and appropriately marketing and educating both the public and providers, including first responders, on a full continuum of crisis resources that focuses on alternatives, including the 988 crisis hotline, mobile crisis teams, crisis stabilization, mental health crisis respite, and drop-in programming.

Currently there are four beds of mental health crisis respite in Erie County, which we operate, and four beds in both Chautauqua County and Cattaraugus Counties together, which we operate, and those are the only mental health crisis residents' beds available across those

three counties.

These programs are highly effective in diverting people from hospital emergency and inpatient settings, but are often not funded at a level that allows for consistent and quality staffing or effective community marketing. We have inadequate community crisis supports funded in an inadequate level to provide competitive pay for quality staff and community education and marketing about viable alternatives to hospitalization.

Stronger investment in and utilization of these proven service models will ultimately reduce reliance on costly and sometimes ineffective hospital systems as the primary provider of mental health crisis care. I have provided additional information and recommendations in my written testimony, including the impact of housing and homelessness.

And in conclusion, on a personal note, I live in Chautauqua County, and I have several family members that have had to either move away from the area to get appropriate services, or just don't have services at all for their mental health and substance use concerns. So it's

important to me both on a systemic level and a personal level that we talk about peer-operated services and how they can help serve the community and fill in those gaps that aren't provided by traditional mental health services. Thank you.

(applause)

FRANK CERNY: Thank you, Attorney General, for bringing this together.

AG LETITIA JAMES: How are you, sir? Thank you.

FRANK CERNY: I represent the Rural Outreach Center located in the southern part of Erie County. We represent parts of western Wyoming County, northwestern Alleghany County, the norther part of Catt County, and a little bit of Chautauqua County. All of those rural areas. And I must say representing rural areas, we are used to being at the bottom of the agenda for most of these things.

The incidents of domestic violence, suicide, and many other social ills is higher, the incidence is higher in rural areas than in metropolitan areas. That's a statistic that most people don't know. Related to that, then, is

higher incidence of mental health (indiscernible) and other issues that need to be dealt with.

This on top of the fact that there are no resources, no resources available to these areas, and accessibility is a difficult issue. So in what we call ROC County, Rural Outreach County, there are 8,500 people without access to transportation. Let that sink in for a young child who's trying to have a normal childhood.

AG LETITIA JAMES: Mmm.

FRANK CERNY: It doesn't work. So we have developed a model where we try to bring all of the resources needed for our population in one place to eliminate all of these other transportation related barriers, and we provide assistance for transportation.

We measure outcomes. We measure housing changes. We measure changes in mental health. We measure changes in cash reserves. We measure everything we do. Our model works because we know that in any given year 50 percent of our people improve their mental health status. Over 60 percent of our people improve their housing, and so on.

We recognize that you cannot treat

mental health issues in silos, particularly in rural areas, because people cannot get themselves from one place to another place to another place. We have had municipalities tell us -- when we ask for public support, tell us that they don't need to help us because all we need to do is send them to Buffalo, Olean, Warsaw, and other municipalities. That is unfair. That's not a way to treat a large part of our population.

So we advocate for our rural population different solutions because they're different issues. And I urge you to listen to the voices of the rural population. Thank you.

AG LETITIA JAMES: Thank you, sir.

(applause)

MICHELE BROOKS: Hello. I'm Michele Brooks. I'm here as a family member for my daughter, but I also have a lot of experience having been a member of the National Alliance on Mental Illness of Erie County and their previous Executive Director.

I'm speaking today for my daughter as well as other who've experienced the deplorable and inhumane conditions at the -- at CPEP at ECMC. There's been references made to that --

you know, the conditions there, but I think it's really important to highlight in more detail what those conditions are.

I want to first say that I've worked with compassionate and caring wonderful professionals and staff there, and worked with them over the years. And I just want to say that that is not my primary purpose of talking about CPEP.

My daughter had a crisis back in April. It lasted over several days. And as a last resort, we ended up at CPEP. She was first ushered into a cold room. I was with her at that point while wearing just very thin, you know, hospital scrubs. She had to actually ask -- I had to advocate to get her a sheet to cover herself and be -- but we were sitting there freezing, you know, air blowing down on us when three people burst into the room, three males, one of them a security guard, you know, with a police officer with his, you know, very intimidating uniform.

She was then entered into the CPEP area with the -- you know, with locked doors as has been mentioned. She had a long wait time, as

many others have, some as long as, you know, over 60 hours. They're given no expectation of how long they're going to be there. There's only chairs. You cannot sleep. There are no beds. People sleep on the floor, on the hard floor.

There were three reclining chairs, which were, you know, occupied. And as my daughter, it was every man, you know, for himself. She was able to get a couple of chairs and put them together to create somewhat of a bed, but said anyone new to the room was just -- it was up for them to find a place to sit.

She was afraid, very afraid. There was males and females together in this room in this clothing that makes you feel extremely vulnerable. She said some people inadvertently that were exposed wearing these clothes. She was afraid of people with varying degrees of mental illness were walking around. Somebody kept coming to stare at her.

There were, you know, altercations. She was afraid to use the bathroom because she'd lose her chairs. She -- there was urine on the floor. She said it was Cuckoo's Nest. I've heard that on several occasions. She was scared

to get water from the water pitcher. It was on a table which happened to be surrounded by staff that were hanging out there.

There's bright lights. There's televisions. There's noise. You -- there's just no way to sleep. And you're very vulnerable and fragile at that point. I want to make sure I get this in. It's just like mental suffering. I did speak -- when speaking with one of the administrators, she said no one should ever leave the hospital worse than they came in. That was not the case with my daughter.

She disengaged with her therapist, psychiatrist, myself, my family. And you know, I've heard all the reasons. I know the situation well, but as I had reasons are -- they become excuses when they're used to avoid responsibility. And I'm honestly -- we need to move beyond the reasons and come up with some solutions here. And they need to be immediate, not after all these systemwide changes are made, you know, in the future. Something needs to happen now to prevent suffering by people in the emergency room.

AG LETITIA JAMES: Thank you, Ms.

Brooks.

MICHELE BROOKS: Thank you.

(applause)

AG LETITIA JAMES: I look forward to again meeting with the executives at ECMC so that we can address some of the issues that you've raised.

Mr. Cerny, thank you again for representing the interests of the rural community, and I would like to meet with you at some point in time to talk about the issues that you mentioned. I did not know that domestic violence and suicide and mental health were higher in rural counties. And I look forward to, again, you educating me further at some point.

And Ms. Higbee, the beds that you mentioned, I do -- is that sufficient to meet the needs of the ten counties that you cover?

SHANNON HIGBEE: Absolutely not. And there are other respites in other counties, but we do particularly do the mental health respite beds for Erie County and for Chautauqua and Cattaraugus County. And so we have four combined beds in one facility for Chautauqua and Cattaraugus County. We are working to hopefully

bring another 12-bed program online in Chautauqua County. It's fighting for funding for that.

As part of the Kirsten Vincent Respite and Recovery Center, that will add eight additional intensive respite beds to serve those individuals that fall in between that short-term crisis residence level of support and the hospital level of support to continue to fill that gap for those individuals that aren't being admitted to CPEP but still need support.

That will add eight additional beds in the first quarter. We certainly don't think that that's going to long-term be sufficient because, as others have mentioned, crisis stabilization centers, which we're also a part of --

AG LETITIA JAMES: Yeah.

SHANNON HIGBEE: -- are great for 23 hours and 59 minutes, but there has to be somewhere to go after that. And so we're working to develop those where-do-you-go-after-that resources concurrently with crisis stabilization centers. However, we're self-funding at this point, so --

AG LETITIA JAMES: Wow.

SHANNON HIGBEE: -- we went out and

raised funds from the county from, as April Baskin mentioned, Chairwoman Baskin, the county legislature gave some. But the majority of the funds for the Kirsten Vincent Respite and Recovery Center came from community foundations like OSHI, like Tower, like the Patrick Lee Foundation, and others who stepped up to help us fund resources because the State isn't funding them at a level that is consistent with the need.

AG LETITIA JAMES: Well, we will join with you to make sure that you get some of those state funds as proposed by the governor of the state of New York, and also to provide a marketing program so first responders divert individuals from hospitals. I thank you all for your testimony, and I look forward to working with each and every one of you.

(applause)

AAG STEPHANIE CALHOUN: Our final panel of the afternoon Cindy Lee, OLV Human Services Lackawanna, Elizabeth McPartland, Children and Family Services Buffalo. Just remember to speak into the microphone. A hard stop at four minutes, and I'll try to cue you to help you along.

CINDY LEE: Thank you, Madam Attorney General, for the opportunity to share with you and your team our experience providing mental health services and our recommendations for improving access to and quality of mental health services in western New York.

AG LETITIA JAMES: Thank you.

CINDY LEE: My name is Cindy, and I am the CEO of OLV Human Services. As a quick background, OLV is the legacy of Father Nelson Baker who, in the late 19th Century created a place for the care of orphans, pregnant and mothering teens with and without families, and children rejected by their families for unmanageable behavior.

Today OLV provides mental health services to approximately 12,000 individuals annually with a wide array of services. Residential treatment for children and adolescents, early assessment in intervention for young children displaying behavioral or developmental problems, schools for children from ages 3 through 21 with developmental, behavioral, and mental health challenges, an outpatient mental health clinic, and group homes for

developmentally disabled adults.

I'm proud to say that OLV also operates an intensive treatment program, the only residential treatment program in New York state for children and adolescents with a dual diagnosis of autism and/or an intellectual disability, and also a mental health diagnosis. This was a cross-systems collaboration with OMH, OPWDD, and the state education department.

One of the root causes of our community's collective shortfall in the provision of and access to mental health services is staffing. And the root of staffing is funding. Our programs rely almost entirely on funding by federal, state, and county government sources with the largest portion from New York State.

Unfortunately, funding has not kept pace with the rising need for mental health services or the macroeconomic challenges affecting wage levels and the job market. When the wages that are offered, which depend largely on the rates set by the various New York state oversight agencies, are not competitive with jobs in the retail, fast food, and other less challenging spheres, staffing becomes a seemingly

insurmountable hurdle affecting the quality of service provision.

Insurance coverage is an area where policymakers might be able to help enhance the provision of mental health services. We are able to provide many services to children if they have Medicaid or are enrolled with the Medicaid Managed Care Plan. For those ineligible for Medicaid but with private insurance, the same level of services are not available.

AG LETITIA JAMES: Hmm.

CINDY LEE: Not all private health insurance plans include children's mental health services. In addition, services that are provided only to Medicaid-eligible children, such as children and family treatment support services, or home- and community-based services, have options that are not available to others.

Those options enhance basic mental health services, but non-Medicaid families cannot obtain them even if they offer to pay out-of-pocket because Medicaid eligibility is a pre-requisite.

AG LETITIA JAMES: Hmm.

CINDY LEE: I would respectfully urge

policymakers to find a way to make these services available to any child in need, not just for those with Medicaid benefits through a combination of regulatory changes and working with the private insurance plans to reimburse for those services.

Lastly in closing, I would be remiss if I did not share an example of the kind of success that can come about as a result of collaboration between the state, local authorities, our expert and caring staff, and the families of the children that we serve.

Jay, a 16-year-old, was referred to our intensive treatment program in 2017. He'd been living on the med surge floor of ECMC for a year because there was no appropriate in-state placement for him. He had a diagnosis of autism along with a mental health condition.

His mother had passed away and his father was very ill, which made being home not possible. When Jay was admitted to OLV, he had limited verbal ability and was self-abusive, which included biting himself and rectal digging to the point of making himself bleed.

Because of these behaviors, going into

the community was not possible, and Jay required supervision 24/7 to keep him safe. During his stay, Jay's father passed away leaving him with limited discharge options. The average length of stay in our intensive treatment program is approximately six months. Jay's was one and a half years.

Over that time, as a result of skilled therapeutic behavioral and educational supports, he was able to participate in community recreation activities, experienced opportunities to visit extended family members at their home, and established a school routine. His self-injurious behaviors were significantly reduced.

Jay currently resides in a group home, and remains with us for his education, and he will graduate in June. Jay's progress exemplifies the life-changing success that we can achieve when we collectively work towards providing the time, human, and financial resources for those in our community facing developmental and mental health challenges. I thank you for your time and your concern on this important topic.

AG LETITIA JAMES: Thank you for ending

with a great story.

ELIZABETH MCPARTLAND: Thank you, Madam Attorney General, for providing a platform to learn about mental health access in western New York. I'm Elizabeth McPartland, President and CEO of Child and Family Services. Child and Family Services supports youth and adults with mental health illnesses through a number of programs, including home-based and outpatient counseling, special education for youth with emotional needs, intensive case management for children experiencing psychiatric challenges, and residential psychiatric treatment for children.

During the last three years, we have seen an increase in the number of children needing help as well as increased severity of their symptoms. Greater demand for mental health supports combined with an insufficient number of professionals able to provide this life-saving intervention has resulted in a crisis in our community.

The scarcity of providers is due to a number of factors, including low wages tied to insufficient reimbursement rates and burdensome regulations. Local agencies like ours have

significant waiting lists for children to receive mental healthcare. We hear from families, and we've heard from them today, who have waited weeks and months to obtain treatment.

Quite simply, we cannot find and hire licensed and unlicensed professionals fast enough to keep up with the demand. Agencies are competing for the same providers who experience high caseloads and high productivity demands. Many clinicians leave this fast-paced work to open private practices or join online telehealth practices. With improved reimbursement rates, less oversight regulations, and fewer documentation requirements, or clinicians move into different career paths all together.

In addition to disrupting patients' treatment, the exodus of licensed providers into private practices magnifies an existing equity issue. Most of these outpatient practitioners do not accept Medicaid. Others do not take insurance at all. As a result, these Medicaid outpatient programs have become the training grounds for new graduates who then leave for less demanding and more flexible work.

The lack of timely treatment results in

an escalation of symptoms, of course, and ultimately stress on the crisis response teams and emergency rooms of our local hospitals. These entities assist in stabilizing the youth. However, the families are not able to access consistent care for their child's needs outside the walls of the hospital.

Data supports we're anecdotally seeing in our community, according to the Office of Mental Health vital signs dashboard in western New York 29 percent of children receive no follow-up care after mental health hospitalization. Despite these challenges, I remain hopeful that New York State can care for our children.

However, we need the Attorney General's Office to be an advocate for our families. Specifically, I respectfully urge you to examine professional requirements for providing care to the Medicaid population. The oversight required for licensed mental health counselors and licensed marriage and family therapists is handcuffing Article 31 clinics and driving many of these professionals into private practice.

Children and families with Medicaid

subsequently have access to a very limited number of providers compared to those with private insurance or those who can self-pay. Modifying key regulations related to the supervision of these professionals, as well as allowing utilization of graduate students and increased frequency of licensing exam offerings could expand the number of available professionals to provide treatment.

I would be remiss if my comments did not point out a fragile population, which is not receiving the attention and support that it deserves. Children in the child welfare system who are often the victims of abuse and neglect far too often fall through the cracks of our systems waiting significant periods of time for treatment, at times not qualifying for various mental health services.

This is sometimes due to rules, and other times due to professional bias. Instead of receiving adequate treatment, youth are labeled as behavior problems and far too often fall into the criminal justice system. In western New York, our organizations are resilient and solution-focused. However, our system is failing

many youth requiring that kids fit criteria in order to qualify for specific programs delaying life-saving treatment and at time blocking their access to care all together.

It is disjointed and requires both additional funding and modified regulations to recruit additional people into this profession and allow flexibility in how we care for our community. Thank you.

AG LETITIA JAMES: Thank you. Ms. McPartland, because of the late hour, do you have these recommendations in your written testimony? You laid out a number of recommendations and I want to follow up on some.

ELIZABETH MCPARTLAND: I will ensure that it's there, and both of our organizations participate in the New York State Coalition for Children's Behavioral Health. And you have had staff that have met with our coalition --

AG LETITIA JAMES: Mm-hmm.

ELIZABETH MCPARTLAND: -- to hear more about these regulatory barriers. So I am grateful for that, and we will continue to send information that way.

AG LETITIA JAMES: Yes. We want to

look at those regulatory barriers.

And Ms. Lee, the private insurance that you spoke of which does not include children's mental health services, do you -- in your written testimony, do you provide the names of those insurance companies?

CINDY LEE: I can.

AG LETITIA JAMES: You could?

CINDY LEE: Yep.

AG LETITIA JAMES: Thank you. I would appreciate that. And also any regulations that needed to be changed to address the needs of those children --

CINDY LEE: Yes.

AG LETITIA JAMES: -- with respect to insurance coverage.

CINDY LEE: Mm-hmm.

AG LETITIA JAMES: I thank you both for your testimony. And I know that everyone here was talking about staffing, and I'm so glad that you focused on staffing and the need for additional resources to increase the staffing levels at both of your organizations. Thank you both and we will be in touch.

ELIZABETH MCPARTLAND: Thank you.

AG LETITIA JAMES: I want to thank everyone for joining us today. Yes, we've discussed hard topics, and we've heard really difficult stories. We heard from a number of individuals, but I am especially grateful for all of those who have stayed, and those who have spoke about their struggles and their losses. Thank you so much for your brave testimony and for overcoming the stigma to talk about the issue of mental illness.

And to the 21 individuals who spoke today, and the dozens of others who have already provided written testimony, I want to thank you very much. As was mentioned, we will review each and every testimony and follow up on the number of recommendations. We will be having other hearings all throughout the state of New York. And also, some of our recommendations we hope will be incorporated in the state budget as they negotiate the budget.

Today offered us the opportunity to look at the current state of our mental healthcare system. We talked about the need for resources, obviously staff, a number of challenges with the civil service system, peer

advocates, trauma-informed approach, equity, addressing the stigma, insurance parodies prevention, alternate means of care, and a host of other issues.

I started today's hearing with outlining some of the unique issues and obviously you have provided additional issues that are unique to western New York. We've heard about these issues that have helped exasperate the mental health crisis that we find ourselves and our communities in, and we've heard about the difficulty people experience trying to get into residential health facilities, and also alternative means of healthcare.

And also the need for, obviously, peer advocates, and the need for staffing, staffing, staffing. We heard about the lack of resources for support, which unfortunately quickly turns into individuals in the criminal justice system, which obviously should not be the correct approach and/or our juvenile justice system.

We've heard from public officials, advocates, family members, not-for-profits, and through it all it was clear that our state is facing a mental health crisis, and it needs to be

resolved. There's no quick fix to solve this crisis, but the fact doesn't mean that we should throw up our hands and lose hope. I am someone who doesn't believe -- who does not drink, but each and everyday I wake up drunk on hope.

So with that -- so it means we've got to roll up our sleeves, we've got to get to work, and this is -- today is really all about, the stories that we've heard, the experiences that have been shared. And many cases have been heart-wrenching almost bringing me to tears. But obviously, I am someone who is really committed to getting things done, and obviously focusing on the passion that was exemplified today, I am more motivated than ever before.

We've got to redouble our efforts, redouble our focus, and the focus of my team here today will -- we will work with all of you in this room to address this crisis. The testimony provided both from this hearing and as written testimony will be invaluable to all of us as we move forward with recommendations. And my office, as I mentioned, will read everything.

So I thank all of you here today, and thank you for your hospitality, your warmness.

Thank the library again. We love western New York. This is not my first visit. I will be back again and again and again until we get this right. And I know that, again, I'm going to be depending on all of you to provide the information because all of you represent individuals on the ground, and you're closer to this issue, and it's really critically important that we lean on your experience.

With the information we collected, we will work to help all New Yorkers impacted by the mental health crisis using traditional means of care, and also non-traditional means of care. And with that, I wish you all a great afternoon and a great evening. And may God continue to bless each and every one of you. Thank you all.

(End of recording)

C E R T I F I C A T I O N

I, Sonya Ledanski Hyde, certify that the foregoing transcript is a true and accurate record of the proceedings.

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Date: January 31, 2023

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