The New York State Conference of Local Mental Hygiene Directors, Inc.

Joint Legislative Budget Hearing on Mental Hygiene SFY 2025-2026 Executive Budget Proposal

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Testimony Presented By:

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Chairs Krueger, Pretlow, Brouk, Simon, Fernandez, Steck, Fahy, Santabarbara and other distinguished Committee Members, thank you for the opportunity to testify before you regarding the SFY 2025-26 Executive Budget.

My name is Courtney David, and I am the Executive Director of the New York State Conference of Local Mental Hygiene Directors ("the Conference").

The Conference was created pursuant to section 41.10 of the Mental Hygiene Law and its members are the Directors of Community Services (DCS) for the 57 counties and City of New York. The DCSs serve as the CEO of the Local Governmental Unit (LGU), defined in the statute as the portion of local government responsible for mental hygiene policy and for the planning, development, implementation, and oversight of services to adults and children in their counties affected by mental illness, substance use disorder, and intellectual/ developmental disabilities.

The DCS plays a critical and unique role as the connection between the State Mental Hygiene agencies (OMH, OASAS, OPWDD) and the people they serve locally. The DCS has direct interaction with all the various health and social service systems in their communities. This provides a critical and rare lens into the needs and challenges of the State's most vulnerable populations. Most often, these needs are not limited to a single service, they are complex and extend beyond the scope of behavioral health care into other distinct areas, such as housing, school/employment, public benefits, food/social needs, and the criminal justice system, including the county jail. The DCS role requires an in-depth understanding of a cross-system county service system, making their expertise essential for the effective development and implementation of mental hygiene policy.

My testimony today outlines the Conference's State Budget priorities for SFY 2025-26:

- **Reforming the State's Competency Restoration Process**
- **20% Administrative Increase to LGU State Aid for County-Based Single Point of Access Programs (SPOA)**
- **Clinical Records for Assisted Outpatient Treatment (AOT) Orders**
- **Mental Hygiene Workforce Recruitment and Retention Funding**
- **Increased State Aid Funding to the LGUs to Sustain Jail-Based Substance Use Disorder (SUD) and Medication Assisted Treatment (MAT) Programs**

The Conference strongly supports the Governor's Executive Budget investments in SFY 2025-26 that seek to build upon prior years' expansion of mental health, substance use disorder, and intellectual/developmental disability programs and services. Many of the initiatives outlined in this year's budget proposal will help to protect New Yorkers who continue to struggle with connecting to appropriate treatment including housing, intensive and integrated supports; as well as providing

indirect supports such as job training, insurance parity, and targeted inflationary increases for the recruitment and retention of community-based providers. The culmination of these investments will ultimately help to achieve better health and stability throughout our communities. Ongoing consultation with the DCSs will also ensure the advancement of any state policy and/or locally-based financial investments are appropriately planned for in the current operating environment, and we thank our State partners for the continued collaboration.

Reforming the State's Competency Restoration Process

Untreated mental health conditions can have a significant impact on the health and well-being of individuals and society, this can lead to increased risk of homelessness and interactions with law enforcement and the judicial system. In March of 2023, approximately 31.5% of New Yorkers reported experiencing poor mental health. The NYS Unified Court System stated in October 2023, "The vast majority of our nation's incarcerated individuals suffer from mental illness, have a substance use disorder, or both. The prevalence of mental illness cannot be overstated, nor can its enormous impact on every aspect of our court system, including our criminal, civil, and family courts."

While the State continues to make needed investments into new programs and services that can help divert individuals with serious mental illness (SMI) from interacting with the criminal justice system, competency restoration orders are significantly increasing for defendants who exhibit challenging behaviors in the courtroom.

Defendants with felony-level charges who are found to lack the capacity to stand trial (i.e. who do not understand the charges against them or are unable to participate in their own defense) are sent to state hospitals to be restored to competency so they can stand trial. Restoration services are not treatment, and are extremely expensive, about $1,300.00/day. One hundred percent (100%) of the costs for these services which are delivered in a **state-operated hospital** are paid for by the counties. This financial burden is accentuated by the fact that Judges who believe they are helping a mentally ill defendant to get "better" by ordering restoration are often operating under the mistaken belief that they are providing the defendant with traditional mental health treatment.

The Conference, along with our partners at the NYS Association of Counties (NYSAC), have proposed amendments to the statutory framework that governs competency restoration, and we applaud Senator Brouk for her sponsorship of S.1004 in 2025 which includes significant reforms to archaic sections of law that govern this process.

Since 2020, the state has charged counties 100% of the costs of restoring mentally ill defendants to competency. **Over the last four years, this policy action has diverted hundreds of millions of dollars away from the local mental hygiene systems of care.**

The State must also not ignore the reality that individuals who enter the restoration process often have complex needs, which may include behavioral health conditions, cognitive and neurodevelopmental impairments, and often, an undiagnosed history of traumatic experiences. The DCSs are often very familiar with these defendants, but there is currently no requirement that courts or the Office of Mental Health (OMH) consult with them on treatment planning; consequently, all decision-making is left up to the State's forensic providers. It is estimated that between 1/4 and 2/3 of all defendants committed for competency restoration under Criminal Procedure Law (CPL) Section 730 end up going through the system multiple times on the same charge — equating to hundreds of people each year.

Since 2019, the DCSs have seen extraordinary increases in the number of 730 competency restoration orders, placing more individuals with serious mental illness (SMI) into State forensic facilities. Psychiatric examiners have said the majority of these 730 defendants can be restored within 90-120 days, however, some ***defendants have been kept in restoration for periods of 3, 6, or even 10 years***. ***This egregious practice has led to further decompensation of these individuals' illnesses and violates their basic human liberties.***

Additionally, these lengthy confinements have been declared by the U.S. Supreme Court to violate the Americans with Disabilities Act, and we are witnessing other states beginning to reexamine and update their laws governing competency restoration in an effort to avoid legal action.

The OMH forensic daily rate for defendants placed for restoration is now approximately $1,300 per day, and the DCSs have no insight into the justification for these costs or why per diem rates continue to increase from year to year.

Below is an analysis of CPL730 costs for the top counties in each census bracket, indicating the largest percentage increase in costs between 2019 and 2024.

CPL730 Costs Analysis Report for Counties with Census < 100,000

County	Census (2024)	Total OMH CPL730 Costs (2019) *(50% county)*	Total OMH CPL730 Costs (2023) *(100% county)*	Total OMH CPL730 Costs (2024) *(100% county)*	Increase 2019-2023 (%)	Increase 2019-2024 (%)
Delaware	44,046	$49,185.00	$51,292.00	$327,557.00	4	566
Washington	59,284	$74,815.53	$184,636.86	$440,047.82	147	488
Warren	65,333	$14,895.23	$834,720.43	$1,642,344.61	5504	10926
Livingston	60,976	$11,361.87	$625,362.56	$755,439.35	5404	6549
Chemung	81,009	$45,442.28	$565,458.37	$1,058,436.15	1144	2229

CPL730 Costs Analysis Report for Counties with Census Between 100,000 and 250,000

County	Census (2024)	Total OMH CPL730 Costs (2019) *(50% county)*	Total OMH CPL730 Costs (2023) *(100% county)*	Total OMH CPL730 Costs (2024) *(100% county)*	Increase 2019-2023 (%)	Increase 2019-2024 (%)
St. Lawrence	106,791	$127,012.22	$717,774.52	$1,009,885.65	465	695
Ontario	112,507	$481,369.35	$572,681.22	$1,787,042.30	19	271
Rensselaer	159,189	$288,038.00	$556,531.01	$784,140.00	93	172
Niagara	208,447	$569,431.00	$1,117,728.00	$1,258,482.00	96	121
Oneida	226,752	$1,907,942.96	$6,087,001.87	$5,381,882.22	219	182

CPL730 Costs Analysis Report for Counties with Census of 250,000 or More

County	Census (2024)	Total OMH CPL730 Costs (2019) *(50% county)*	Total OMH CPL730 Costs (2023) *(100% county)*	Total OMH CPL730 Costs (2024) *(100% county)*	Increase 2019-2023 (%)	Increase 2019-2024 (%)
Dutchess	296,691	$323,041.00	$1,904,977.00	$1,632,025.00	490	405
Albany	317,397	$429,083.03	$930,055.49	$6,059,149.88	117	1313
Orange	408,449	$539,566.87	$2,056,307.73	$2,744,400.43	281	409
Erie	943,871	$937,708.52	$5,130,978.68	$4,607,040.96	447	391
Westchester	989,898	$1,157,057.19	$3,307,943.18	$4,483,734.21	186	288

Enactment of our proposed competency restoration reforms, outlined in S.1004, in the final SFY 2025-26 budget is critical and will ensure that these high-needs individuals who are unable to be restored to competency solely due to their illness can receive the most appropriate treatment for their diagnoses. It will also ensure the millions of dollars currently directed to the State's General Fund will be available to the local mental health departments for reinvestment back into the critical services needed to support criminal justice diversion programs and community-based care.

20% Increase to LGU Administrative State Aid for County-Based Single Point of Access (SPOA) Programs

In SFY 2000-01, the Single Point of Access was created to provide a more streamlined process for linking and providing timely access to intensive services and supports. SPOA Coordinators have been embedded under the authority of the DCS/LGU and serve both adults (A-SPOA) and children (C-SPOA) to help achieve community-based mental health systems that are cohesive and well-coordinated. These county-based programs are critical to effective systems of care, ensuring

individuals and families are connected to the appropriate array of services available. By streamlining access to services through placement referrals, individualized care coordination including case management and housing assistance, and ensuring accountability between systems and providers - these coordinators bridge service gaps, simplify complicated networks and procedures, and serve as liaisons and advocates for individuals navigating the maze of local services and care systems.

SPOA Coordinators maintain ongoing contacts and linkages with a variety of locally-based systems in order to obtain connections to programs necessary for those being served. SPOA prioritizes services for people with histories of homelessness and/or involvement with the criminal justice system and helps individuals maintain consistent and integrated care, reducing the likelihood of crises, and hospitalizations. Additionally, SPOA programs ensure local resources are used efficiently, avoiding duplication of services and supplanting state funds.

Over the past two decades, the State's Medicaid redesign, changes and expansions to mental hygiene programs, and the ever-increasing complexity of cases have continued to evolve the SPOA role, resulting in a significant increase in coordinator responsibilities. However, the resources to sustain these positions are mostly borne by the counties. State Aid funding to the LGUs to support these valuable programs and positions has remained stagnant, forcing the counties to braid and blend local funding to pay for these valuable services. While the State has made significant investments in local programming to support effective cross-system service delivery to address the complex concerns that many adults and children require across the state, SPOA programs have been overlooked.

Many rural counties across the state operate direct clinic services and have far less service capacity and resources to sustain these programs and positions. In some rural counties, SPOA Coordinators are part-time, when a full-time position would be the most beneficial to support the wide range of interventions required for their community.

In New York City, SPOAs are particularly critical because of the city's dense population, high demand for services, and the complexity of its mental health and housing systems. SPOA serves as a vital mechanism to ensure equitable, timely, and effective access to support for individuals with significant mental health or housing needs. NYC C-SPOAs also integrate Parent Advocates into their model, offering tailored family support services and maintaining outreach to families while they await services.

The Department of Health (DOH) and OMH have specifically underscored the value of the C-SPOA programs and have supported policies that expand these programs. Unfortunately, state funding has not followed state policy development, which has significantly increased the roles and responsibilities of these coordinators over the past several years.

C-SPOAs are often the only constant for families who have sought services across the child-serving system. Uniquely positioned as the “holders” of a family’s story across programs, providers, and systems, they help maintain continuity and ensure that critical information is not lost as families navigate complex and often fragmented services.

It is time for the State to add funding to support the LGUs' administration of these important positions within the county. **We hereby request your support for a 20% administrative increase to LGU State Aid** as a significant first step towards ensuring each county has the ability to fully stand up these programs and supports. We must ensure these programs remain viable and SPOA coordinators can do what they do best which is continuing to serve as a key foundational building block for the implementation of effective systems of care locally.

Clinical Records for Assisted Outpatient Treatment (AOT) Orders

The Conference strongly supports the Governor's inclusion of $16.5 million ($6.9M NYC/$9.6M ROS) to counties for the enhancement of Assisted Outpatient Treatment (AOT) programs across the State.

Kendra's Law was established in 1999 after Kendra Webdale tragically died after being pushed in front of a subway train by a man with untreated schizophrenia. This law allows judges to mandate outpatient treatment for individuals who, due to their mental illness, pose a risk of harm to themselves or for individuals who do not voluntarily comply with treatment.

AOT provides court-ordered mental health services to individuals with severe mental illness who meet specific criteria. These programs aim to ensure that individuals who struggle to maintain treatment voluntarily receive the care they need to avoid hospitalization, homelessness, or interactions with the criminal justice system.

The court evaluates the case, and if the criteria are met, it issues an AOT order. These orders outline a specific outpatient treatment plan the individual must follow. The plan is developed collaboratively by mental health providers and includes services such as medication management, counseling, case management, substance use disorder (SUD) treatment, and housing assistance.

Court-ordered treatment ensures individuals receive care, even if they are initially resistant to it and when, due to their illness, lack insight into the need for treatment. Research shows that individuals in AOT programs experience fewer psychiatric crises, hospitalizations, and incarcerations. AOT also provides relief to families by ensuring their loved ones receive the necessary care and helps to reduce the emotional burden of navigating treatment systems alone.

Each county has a designated AOT Coordinator, embedded under the authority of the DCS/LGU that works to oversee and implement AOT programs. Like SPOAs, AOT Coordinators are valuable positions within the county and assist with preparing AOT petitions, ensuring all legal and clinical criteria are met. These Coordinators work closely with other mental health professionals, attorneys, and family members to file the appropriate paperwork in court. They facilitate the coordination of services, including the development and implementation of treatment plans which are tailored to the individual's needs.

Collaboration with community-based providers, such as outpatient clinics and psychiatrists, is a key responsibility of these positions, which helps to ensure compliance with the court orders. AOT Coordinators gather monitoring reports to oversee the effectiveness of service provision and individuals' compliance with treatment. They coordinate the execution of MHL 9.60 pick-up orders to ensure care, as well as individual and community safety when compliance lapses. These Coordinators, in consultation with the DCS/LGU, collect data to evaluate the effectiveness of the programs locally and submit reports to OMH to ensure statutory and regulatory compliance.

A key piece to the effective coordination and facilitation of service provision as part of the AOT process is access to the clinical records of the individuals placed under these orders. As outlined under Article 33, section 33.13 - clinical records; confidentiality, the DCSs and/or his/her designee, have the legal authority to be provided with clinical records for these cases.

However, a 2011 legal case, "In the Matter of Miguel M" has restricted DCS access to clinical records in some AOT court hearings across the state. By way of background, a designee of the New York City Department of Health and Mental Hygiene (DOHMH) had petitioned for an order under Mental Health Hygiene Law 9.60 requiring assisted outpatient treatment ("AOT") for Miguel M. At issue was whether the Privacy Rule, adopted by the federal government pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), 42 U.S.C. 1320d-2, prohibited a respondent from disclosing, at the petition hearing, records from two hospitals related to three occasions on which Miguel was hospitalized. The court held that the Privacy Rule prohibited the disclosure of a patient's medical records to a State agency that requested them for use in a proceeding to compel the patient to accept mental health treatment where the patient had neither authorized the disclosure nor received notice of the agency's request for the records. Accordingly, the medical records at issue were not admissible in a proceeding to compel AOT.

The DCSs have specific legal authority under Article 41 of MHL for the management and oversight of services for adults and children connected to the three mental hygiene systems locally. Access to clinical information for individuals connected to inpatient, outpatient, or community-based programs is allowable under law. Therefore, restricting access to clinical records for these clients creates an unintended consequence whereby making it impossible to ensure appropriate care coordination is provided to these individuals. **We hereby request your support for the inclusion of the provision attached as Addendum #1 as part of the final enacted budget for SYF 2025-26.**

<u>Mental Hygiene Workforce Recruitment and Retention Funding</u>

The Conference strongly supports the Governor's proposal to include a 2.1% Targeted Inflationary Increase (TII) for eligible mental hygiene and other human services programs for the period April 1, 2025, to March 31, 2026. This increase will provide flexible financial support to assist the DCSs/LGUs and not-for-profit providers with increasing administrative and programming costs.

While this investment is appreciated and a significant step towards sustaining the critical workers our systems rely on, a workforce crisis remains. Without a larger level of investment and long-term sustainable solutions that support the recruitment and retention of mental health workers, the

implementation of new or expanded local service programs will be unrealized and our systems will fail those individuals they are designed to serve.

Across the State, we are seeing the impact of our diminished workforce, as individuals in crisis are all too often becoming involved in the criminal justice system and/or being referred to and languishing in Emergency Departments (EDs).

Agencies have also had to scale back on satellite locations due to staff vacancies. High percentages of adults and children/youth with complex needs have been unable to receive the necessary treatment. Outpatient mental health clinics, many of which are county-operated and serve as the backbone of service provision in the State's rural areas, are severely struggling with workforce needs. Staff vacancy rates for master's-level therapist positions continue to increase while demand for services has risen. Programs have decreased or eliminated same-day access to services.

Experienced clinicians are leaving for higher-paying jobs in private practice or jobs in the telehealth industry. While programs will continue to see individuals with acute needs, as this is a regulatory requirement, other individuals have experienced longer wait times for service or longer wait times in between appointments.

Workforce shortages create a vicious cycle. Staff left behind become overburdened, contributing to further burnout and attrition. The care of individuals receiving services is significantly disrupted when their trusted therapist leaves. All of this ultimately results in increases in criminal justice involvement, homelessness, emergency health visits, and in many cases, deaths.

The outpatient behavioral health system needs higher reimbursement rates that will allow agencies to maintain reasonable units of service and caseload expectations for their staff members, as well as statutorily-driven annual cost of living increases, and continued reduction of administrative burdens (including paperwork).

As the need for services is increasing and entry into the "helping" professions is decreasing, a long-term approach to crafting solutions is also necessary. This includes the creation of job pathways beginning in high school, and clear career development/advancement programs at the community college level, including scholarship opportunities and easily accessible student loan forgiveness programs.

Therefore, in addition to the 2.1% TII, we ask for your support to include an additional 7.8% increase for mental health and substance use disorder reimbursement rates and contracts in SFY 2025-26.

Increased State Aid Funding to the LGUs to Sustain Jail-Based Substance Use Disorder (SUD) and Medication Assisted Treatment (MAT) Programs

The Conference commends the Executive for a continued commitment of $9.084 million for jail-based SUD and MAT programs in this year's budget proposal.

Over the past several budget cycles, the State has committed State Aid funding to the LGUs to develop these much-needed programs in consultation with the Sheriffs. Statewide expansion of these programs has proven to be successful, with more individuals engaged in treatment. However, the counties continue to report a need for additional funding to meet the provisions under the law, and most importantly, to appropriately support the level of resources needed to ensure that all individuals seeking a pathway to recovery can be served.

The costs of Opioid Use Disorder (OUD) medications in every county jail far outweigh the appropriated State funding. The majority of counties receive approximately $160,000 per year in State Aid to support these programs, which includes all clinical supports. Many counties have supplemented the lack of State funds with opioid settlement dollars to maintain compliance with State law.

As local mental health departments continue to grapple with how best to allocate available county resources, increased costs from CPL 730, additional responsibilities for SPOA and AOT programs, workforce needs, and lasting pandemic challenges, the additional strain to supplement this funding will undoubtedly cause a ripple effect in service delivery across our local systems.

Therefore, we request your support to maintain the $9.084M for jail-based SUD/MAT programs as part of the final enacted SFY 2025-26 budget.

Thank you again for this opportunity to testify today. I sincerely appreciate your consideration of these requests and look forward to working with you and your staff on these priorities this budget cycle.

ADDENDUM #1 – LANGUAGE TO SUPPORT DCS ACCESS TO AOT CLINICAL RECORDS

§ 29. Subdivision (s) of section 9.60 of the mental hygiene law, as added by section 2 of subpart H of part UU of chapter 56 of the laws of2022, is amended to read as follows:

(s) Disclosures. (1) A director of community services or his or her designee may require a provider of [~~inpatient psychiatric~~] services operated or licensed by the office of mental health to provide [~~contemporaneous~~] information, including but not limited to relevant clinical records, documents, and other information concerning [~~the person receiving assisted outpatient treatment pursuant to an active assisted outpatient treatment order~~,] an assisted outpatient, a subject of a currently pending petition pursuant to this section, or a person who is the subject of an investigation pursuant to paragraph two of subdivision (b) of section 9.47 of this article, that is deemed necessary by such director or designee [~~who is required to coordinate and monitor the care of any individual who was subject to an active assisted outpatient treatment order to appropriately~~] in the discharge of their duties of care coordination, care monitoring, or investigation pursuant to section 9.47 of this article[~~, and where~~] or treatment plan development pursuant to subdivision (i) of this section; provided that such provider [~~of inpatient psychiatric services~~] is [~~required~~] permitted to disclose such]information pursuant to paragraph twelve of subdivision (c) of section 33.13 of this chapter and such disclosure is in accordance with paragraph two of this subdivision and all other applicable state and federal confidentiality laws. None of the records or information obtained by the director of community services or the director's designee pursuant to this subdivision shall be public records, and the records shall not be released by the director to any person or agency, except as already authorized by law.

(2) A requirement to disclose information pursuant to this subdivision shall be in writing and shall be accompanied by documentation demon- stating that:

(i) the identified person consents to such disclosure; or

(ii) (A) the director of community services or the director's designee provided or made a good faith attempt to provide the identified person with written notice of the director's or the director's designee's 1intent to seek such disclosure; (B) such notice was sufficient to provide such person with a reasonable opportunity to challenge such disclosure in court; and (C) either no such challenge was filed or the court resolved such challenge by authorizing disclosure.