Testimony Before the New York City Council Committee on Mental Health, Disabilities and Addiction jointly with the Committee on Veterans

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Presented by:
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Community Access expands opportunities for people living with mental health concerns to recover from trauma and discrimination through affordable housing, training, advocacy, and healing-focused services. We are built upon the simple truth that people are experts in their own lives.

www.communityaccess.org

Thank you to Chairs Lee and Holden, and the rest of the Mental Health, Disabilities and Addiction Committee as well as the Veterans Committee, for convening this important hearing. I appreciate the opportunity to testify on behalf of Community Access.

I am fortunate to serve as the CEO of Community Access, a nearly fifty-year old organization that is one of the most person-centered supportive housing and mental health agencies in New York City. Each day, I work alongside a team of more than 350 people who devote time and care towards supporting thousands of people living with mental health concerns through housing, training, education, mobile treatment and other healing-focused services. I've seen firsthand the transformative nature of accessible, voluntary, community-based resources.

I testify before you today regarding Intro. 0793, which would require the Department of Health and Mental Hygiene (DOHMH) to report how many times city agencies and hospitals submit referrals for individuals to Assisted Outpatient Treatment (AOT) programs under the state law known as Kendra's Law, including the number of petitions filed for such referrals and the number of resulting court orders.

I would like to begin by noting that Community Access supports efforts taken by the City Council to increase transparency around mental health programs and service utilization. At the same time, we are deeply concerned about how this data could be used to expand the AOT program. AOT, or more accurately Involuntary Outpatient Commitment, is rooted in coercion and mandated services. It is a practice that runs counter to the changes that we must see in our public mental health system if we are to successfully engage people who have been ill-served by existing systems and disconnected from care. According to the State's own accounts, the AOT legislation's stated purpose was to, "enhance the support, supervision and coordination of community-based services for persons with mental illness who are at risk of relapse, violence and/or rehospitalization through court-ordered assisted outpatient treatment and other coordination of care measures."[1] It was also aimed at solving the "revolving door syndrome" of individuals going in and out of involuntary hospitalizations while providing a less restrictive alternative to forced hospitalization.[2]

The truth is that AOT strips people of their rights, and for those people who have first-hand experience under AOT orders, they often report it as being highly coercive. In New York, AOT orders have disproportionately impacted people of color, communities already subject to over-policing and monitoring.

Statewide, 38% of people under AOT orders are Black, 31% are white, 26% are Hispanic, and 4% are Asian. Black and Hispanic New Yorkers are over-represented in the AOT program compared to their proportion of the state population, which is 17.6% Black, 69.6% white, 19.3% Hispanic or Latino, and 9% Asian.[3] A 2005 report from the New York Lawyers for the Public Interest found

[1] https://digitalcollections.archives.nysed.gov/index.php/Detail/objects/19966
[2] https://my.omh.ny.gov/analyticsRes1/files/aot/aot-2009-report.pdf
[3] https://www.census.gov/quickfacts/NY

that Black and Hispanic people were five and two-and-a-half times as likely to be subject to Kendra's Law, respectively.[4] New York City residents were four times as likely. The disproportional impact on communities of color is just one more way that structural racism manifests in our health and mental health care systems.

We are sure that any additional data collected will continue to highlight these facts, but to what end? Many people are under the misapprehension that AOT is needed because those in mental health crisis do not want care. That is simply not true. In fact, Andrew Goldstein, the man diagnosed with schizophrenia who pushed Kendra Webdale into the path of an oncoming subway in 1999, killing her, was not someone who did not want mental health services. He was someone who repeatedly tried to access services and, again and again, was unable to secure the mental health services he needed to stay well.

It is the position of Community Access that those who are disengaged from care are disengaged because the system is failing - unable or unwilling to offer the services and programs that are truly responsive to people's needs. We fail to listen, to understand what people need and want and act quickly to provide it.

Community Access argues that the state should invest more resources into community-based services, including a range of voluntary, rights-based, person-centered supports. Individuals should be offered a plethora of care options and services to choose from, and the spectrum of mental health sector providers should be trained to understand that people living with mental health concerns are the experts in their own lives and must be true partners in the service relationship, with their preferences guiding treatment. Without that, we will continue to fail to reach those who need timely access to the right kind of support to stay well. Our attention should be focused on fixing a broken system instead of better understanding the implementation of a coercive practice that we should move away from.

I am proud of the work Community Access and other providers, advocates and service users have done to ensure that conversations about mental health service delivery reflect the need for voluntary, person-centered, community-based services. With thoughtful policy choices and investments, along with the use of data and statistics, we can create a more just city that meets people's needs, protects them from harm, recognizes human dignity, and supports them to make decisions about their own health and wellness.

Thank you for the opportunity to submit testimony. I look forward to working with Chairs Lee and Holden and the other members of these committees, as well as our agency partners, to advance community-based service options and ensure providers citywide have the resources they need to offer the support our communities rely on. If you and your staff have any questions, or if Community Access can offer direct support to members in your districts, please reach out to me at chedigan@communityaccess.org or 212-780-1400, ext. 7709.

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[4] NYLPI report https://www.nylpi.org/resource/implementation-of-kendras-law-is-severely-biased/