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CONTACT: pressoffice@cityhall.nyc.gov, (212) 788-2958

TRANSCRIPT FROM FRIDAY, DECEMBER 2, 2022: SENIOR ADVISOR FOR SEVERE MENTAL ILLNESS BRIAN STETTIN IS INTERVIEWED ON FAQ NYC

Harry Siegel: It's FAQ NYC. This is a weekend edition. I'm Harry Siegel here with Katie Honan. And in just a moment we'll be joined by Brian Stettin, who's now the senior advisor to the Adams administration on severe mental illness, and who drafted the legislation that became Kendra's Law as an assistant attorney general in 1999, after a young journalist, Kendra Webdale, was shoved into an oncoming train by a young man from Queens with a long history of mental illness.

Stettin's is here to discuss the Adams administration's new push to have more severely mentally ill people brought to hospitals, with or without their consent, to be evaluated by psychiatrists who can involuntarily hold them for up to 72 hours and to change the state laws governing who can be hospitalized longer term to include people who can't recognize their mental condition or take care of themselves, not just those who present an immediate threat to themselves or others. There's a lot to dig into here, but first, here's a brief message from Katie.

Katie Honan: Hello. FAQ NYC is brought to you by The City, a nonprofit newsroom that holds New York's powerful to account and shines a light on New York City's under covered neighborhoods. And from now through the end of the year, every dollar donated to The City will be doubled, thanks to a very generous matching donation. To power The City and FAQ NYC's essential local reporting, donate at thecity.nyc/give. That's the city.nyc/give.

Siegel: Thanks Katie. And with that welcome, Brian, and let's jump right in with what might be the two big questions about this new plan. First, how is this different from what the city was already doing with police officers and others, somewhat routinely taking people who appeared to be severely mentally ill to hospitals for evaluations? And second, why is it okay to be pushing more people into being evaluated when, by pretty much all accounts, there aren't enough hospital beds, supportive housing options, or other forms of long term care available for those people in need of that help?

Brian Stettin, Senior Advisor For Severe Mental Illness, Mayor’s Office: Okay, so let's take the first one first. This really is not different from our current practice, operationally. There's nothing

in the directive that has gone out from the mayor that suggests that we are going to be creating this new ambitious or aggressive sweep where we're going to have lots more cops out there looking for lots more people and finding more reasons to hospitalize them. I think it's really unfortunate that it's been characterized that way. This is simply about how we do the work that we have been doing all along, which is having our mobile crisis teams out, figuring out ways to help the people who they encounter, having police officers deal with situations that they will just ordinarily encounter on their standard patrols.

And what we have been frustrated with in the way that work plays out under current practice is that there are situations where we feel strongly that a person does meet the criteria to be brought for an evaluation. That is, they are a danger to themselves in that they are unable to meet their basic needs and they are exhibiting clear signs of mental illness. And those two things in combination, when you are unable to persuade a person to accept a voluntary offer to receive a hospital evaluation, do give rise to a legal authority to have someone brought in, when it's apparent that they have untreated severe mental illness and are unable to meet their basic needs.

And in the work that is happening now, it is often the case that because there is this misunderstanding of the law and there is this pervasive belief that any kind of involuntary intervention must hinge on the person being violent or suicidal or engaging in some outrageously dangerous behavior such as walking into traffic. There are situations where people who clearly meet the legal criteria are left alone and shoulders are shrugged. And that's the situation that the mayor is saying is simply not acceptable. We have an obligation both morally and legally in our authority as parens patriae to help these folks.

And that's the policy shift here. It's simply about getting the information to the officers in mobile crisis teams who are doing this work, that in fact you have more ability to help people than you may have realized because of this misunderstanding of the law.

Siegel: Cool. And then the second part there, there's this moral obligation, I'd just like you to break down what bringing people in to have them then evaluated by psychiatrists accomplishes in the absence of beds and supportive housing and so on. That's been a criticism that's been raised since this has been announced.

Stettin: Yeah. Yeah. And one great frustration I've had in hearing so much of the reaction to the mayor's plan is that it's been suggested or just assumed that this is Mayor Adams' big picture solution to what we do about the crisis of untreated severe mental illness in New York City. It suggests that the mayor thinks that we can heal people simply by sticking them in a hospital for a couple days without thinking at all about the continuum of care that is sorely needed and that is sorely lacking in New York City.

When people tell us that the city has a long way to go to kind of build that continuum of care that meets all levels of need and ensures that people receive care in the least restrictive, appropriate environment, they're preaching to the choir. We know that. We have done, I think, some interesting and exciting things on that front and we have a lot more to come. This plan should not be understood in a vacuum.

Our health and mental hygiene commissioner, Dr. Ashwin Vasan, is leading an effort within the administration. I think you are going to see certainly before we put out a new budget next year. The first budget the mayor did was really when we had just kind of come into office. I think it's going to be very interesting when people see what we have coming down the pike in terms of really important plans to push us forward, to build that system that we all know that we need.

But in the meantime, to say that people who are in sore need of hospital care in a particular moment of time, because they have an untreated mental illness that is causing harm to them by allowing them to remain in the street, that we are not going to do anything about that, that we're going to... Look, if we're going to just leave people on the street who are in need of medical care because we don't have the beds and we don't have the services for them, we should at least be honest enough to say that that's the reason we're abandoning people to the street. We should not hide behind this false excuse that we can't help them because the law doesn't allow it.

And so, I think it's been overstated how many more people are going to come into the system through this approach. It's certainly not something we expect to lead to a flood of newly hospitalized people. I think in most cases, it's going to be about hospitalizing someone who was going to wind up in the hospital anyway, in pretty short order, because they were going to decompensate.

So this is about compassion and care and recognizing that somebody in that particular moment in time needs help and we have an obligation to figure out how we're going to give it to them. And so, the work to create that great system of care continues. I think when we are judged in the long term, people will see that we've done a lot on that front.

Katie Honan: Thank you for that Brian, I think it does clarify for a lot of people who read the coverage, watched the press conference (inaudible). I do have a question, what is the status of the training that the mayor discussed for police officers and EMS workers and other people who will be interacting with people on the street before they're brought in? The second part, I guess... If you can answer that first part, against the status, because that is a critical part of it.

Stettin: Yeah, sure. So there is a training component to what we are doing, to get this message out to our police officers and mobile crisis teams. That they actually do have authority to provide help to these individuals who don't recognize their own need for it. And the way we are incorporating that into the training, that I should say that mobile crisis teams and police officers already receive about how to respond to these situations that they frequently encounter in their work. We are enhancing that training by adding a really in depth discussion of this basic needs standard that has, I think, received short shrift.

And so, that's going to consist of vignettes where we're going to describe people who may or may not be able to meet their basic needs. It's going to lead to a discussion of those who are taking part in the training, of whether there is enough here that's been presented to indicate that the person can't meet their basic needs. And we're going to explore options in these situations, in the training as to what might be done before resorting to involuntarily removing somebody to a hospital, in the way of coaxing them to recognize their own need for treatment. That may

actually mean you come back to them in a day or two and don't give up quite so easily and don't say immediately that it's time to take that person to the hospital.

So that discussion of the fact that there is this option to help these individuals is what's going to be part of the training, in a way it really hasn't before.

Honan: And I guess, the second part of that, I know a lot of the concern and criticism, some of it is that shortage of beds or just not enough beds and perhaps not enough psychiatrists and the staff that's able to perform it. So my specific question, I know during (audible), I don't have an exact number, but beds that were reserved, that had been held for, were turned over to COVID response. So I don't know if you know the status of turning those back over and if there will maybe in the coming weeks and months, we'll learn about even additional hiring and then additional beds added.

Stettin: Yeah. So that is primarily a state function. I can tell you from what I've seen statewide, and I think half of these numbers are in New York City, it's been reported that we lost about 1,000 beds that were repurposed to deal with the COVID emergency. And statewide, we've only gotten about 200 of those back in line, and I know that's something that the governor's administration is working very hard to reverse. But that's not a city government function.

Honan: Right. I didn't know you knew if there's communication on it. I know the mayor and governor in October announced this plan to add the additional 50 beds. I don't know if there was any information…

Stettin: So let me just say something about those 50 beds, because I know it's kind of been reported that that seems like such a drop in the bucket in relation to how many beds were lost. I think a detail that's really important here, that hasn't been understood is that those 50 beds are for a very specific purpose. They are long term care beds. Those are going to provide up to 120 days of care for individuals who are profoundly mentally ill and in need of that length of hospitalization. That is a very small minority of the total population of people who rely on psychiatric inpatient care.

And it actually is a very significant number in relation to the number of individuals who actually need that kind of intense care. So it's something we're very excited about. We think it's going to make a real difference in our ability to deal with this very small number of very difficult, challenging, and heartbreaking cases, particularly folks who have kind of taken refuge in the subway. Does that answer your question?

Honan: Yeah. No, it does. You're right. Because it's such a complicated issue and it's multilayered, and it's so many layers in terms of the treatment and care and every single person dealing with the (inaudible) specific different course of care, I think that would summarize it all (inaudible) all the work that's been done.

Stettin: Yeah, this is such a…

Harry Siegel: Can you explain for listeners, explain to me how you properly pronounce the term anosognosia.

Stettin: That's pretty close, Harry. Anosognosia is the pronunciation that I've always gone with. I've heard it done a couple of different ways. But it's a very important concept for people to understand in making sense of why there are individuals who, as painfully obvious as it may be to everyone around them are in desperate need of psychiatric care, cannot recognize it. And it simply means a lack of insight. It means the person has an inability to recognize that they have a mental illness and that they have a need for treatment. And this is something that is kind of a neurological deficit that shows up in about half of people with schizophrenia and severe bipolar disorder. Yeah, I mean, from the perspective of somebody who has anosognosia, it's perfectly rational that they want no part of the treatment that's being offered because they don't believe they have the illness. And this is sometimes kind of casually referred to as the person being in denial. I think it's really important to understand how different this is.

Denial is kind of a universal human defense mechanism and something we all practice. It kind of means you know the truth deep down, but for whatever reason aren't ready to admit it to yourself. That is not what's going on with someone with anosognosia. This is a neurological issue. The information that the person has an illness is simply not reaching the part of the brain that allows them to recognize it. And so when you suggest to them that they have this illness and need for treatment, they think it's you that has a mental illness. It's as absurd to them as it would be if I tried to convince you that you had schizophrenia. And so it speaks to why at certain junctures is in need to make that decision for a person who isn't able to receive the information that allows them to intelligently decide whether or not they want treatment.

Siegel: So implicitly here, and I know this isn't really, it's more of a change in focus, change in policy from the city and talking to psychiatrists who do these screenings and who, by the way, say they haven't gotten any training or specifics yet from the city.

Stettin: Well, I'll have to push back on that. Yeah, so a directive has gone out that all the agencies involved in doing this work have participated in crafting, that states clearly, and we're just really kind of piggybacking on guidance we received earlier this year from the state office of mental health, that makes clear that a person who cannot meet their basic needs as a result of untreated mental illness is a danger to themselves. And so we have very clearly gotten that message to the agencies that are involved in this work. And the training as to what exactly that means is something that obviously is not happening overnight. It's something we're rolling out over a reasonable period of time. But we're certainly not expecting anyone to take action on a policy that they haven't been trained on. We don't expect this to lead to major differences overnight.

Siegel: So there's a new training coming for police and other responders who may be encountering city workers…

Stettin: That's right.

Siegel: Encounter disturbed people in the street. It still seems a little chicken and eggy with sort of announcing this new approach, the work that's been done. Perhaps that's political, but I wondered if you might want to speak to that and how this has been rolled out, particularly as there have been a whole number of headlines that have suggested lots of people are just going to be involuntarily hospitalized, held without their consent. But what you're saying I think sensibly is not actually a dramatic shift in policy.

Stettin: Yeah. I mean, I think it was important to the mayor to make a bold statement that we care about these individuals and that as the mayor said in his speech, as a matter of city policy, no longer acceptable for us to see somebody in crisis, see somebody in desperate need and to walk by them and think, we can't do anything about that. And so to put that marker down and say that, "Don't expect miracles. It's going to take us some time to actually implement this and operationalize it, but this is our operating premise and this is how we're going forward," I think was a really powerful and important thing for the mayor to do.

Siegel: Look, as you know, it's very hard on the street to differentiate between someone who's acting out of mental health issues as opposed to because of substance abuse issues. And the mayor's example, someone's shadow boxing without wearing shoes. If somebody's doing that because of drug abuse, it's going back to consent. There's no path to forcing treatment (inaudible) in New York and there's a lot of indicators of forcing (inaudible) on people is not productive. So I'm hoping you can speak to how the city's severe mental health issues and drug abuse issues intersect and diverge and what this means for this new (inaudible).

Stettin: Yeah, sure. And I think it's really important here to maybe correct the record on what it is that actually police officers and mobile crisis teams are able to effectuate when bringing somebody off the street in a situation like this. And I listened to the podcast you guys did a couple of days ago on this and it was said a couple of times that we're giving authority to people who do this outreach work and to police officers to have somebody hospitalized for up to 72 hours. That's actually not right. The only thing that the mobile crisis team and police officer have the ability to do is have the person brought to the hospital for an evaluation. They are making, basically, what you might call a probable cause determination that this person appears to have a mental illness and appears to be a danger to themselves and bringing them to a hospital for an evaluation to take place.

And at that point, they are looked at by a medical professional, a physician under the current law. And in a clinical setting, they are more formally diagnosed as to exactly what's going on. And it's only upon that happening that the person can be admitted to the hospital. Or if they're brought to a psychiatric emergency program, what we call a CPEP, which we have 12 of in the city, then they can be held there for up to 72 hours. But it's only upon that finding that they actually have that medical need. Now, given that situation, the fact that they….

Siegel: But in the 11-point plan, it seems like you want to expand the number of medical professionals who can do this. Currently, right now, it's psychiatrists. And psychiatrists I've talked to have pushed back very aggressively about that. Psychiatrists of course being medical doctors who could prescribe…

Stetin: Yep.

Siegel: They don't want to have family counsel, marriage counselors for instance, with other (inaudible) be able to make that much bigger, as you're correctly saying, determination. After that up to 72-hour hold where someone is being evaluated by the psychiatrist you mentioned earlier about someone's long term needs, can you speak to wanting to expand that group? And obviously, if you're bringing more mentally disturbed people in, there's a bottleneck issue if it is just medical doctors and mostly psychiatrists where they're performing those screens.

Stettin: So Harry, I can speak to what we're proposing in the legislative agenda. I think it's important to keep in mind that there is nothing in the legislative agenda that impacts the four action items that the mayor's laid out, the things that we think we can do now. But if you don't mind, I'd just kind of like to kind of finish answering your previous question as to how it plays out when someone is actually acting out based on a substance abuse issue rather than a medical issue.

Siegel: My apologies.

Stettin: Yeah, that's okay. That's okay. And then we'll turn to the next question, I promise. But even under the current policy or the current misunderstanding of the law where we're looking for evidence that a person is violent or suicidal or doing something outrageous such as running into traffic. Even under that lens, you're going to have situations where you don't really know in the field whether that behavior is the result of a drug-induced psychosis or a mental illness. And so the only thing you really have to go on is that it appears that the person has a mental illness, and that's going to give authority to have that person brought for an evaluation. But that's as far as that goes. Whether they are ultimately admitted to the hospital is going to depend on what happens when the person's medical history is looked at, and maybe that drug has worn off a little bit, and it becomes apparent whether that person has a mental illness or not. That's what's going to lead to hospitalization. I think that's important to note.

Honan: I just was going to thank you for clarifying.

Stettin: Sure thing. Sure thing. So now in turning to the question of why we think it's important to expand the authority to perform those evaluations in the hospital. Those evaluations, as to the fact that the person has a mental illness and meets the criteria, would not be expanded to professions that do not have just as much training as psychiatrists in mental health and mental illness diagnosis. So we're talking about expanding that to psychologists, psychiatric nurse practitioners, and licensed clinical social workers. All highly degreed professionals whose training in mental illness is really no different from a psychiatrist. Except there is that medical component, of course, to a psychiatrist's training where they have the authority to make medical decisions, that are not really being made at the point when you have someone come into a hospital, and you're simply determining whether they have a mental illness that is likely to cause harm to themselves or others. So to limit that particular function only to psychiatrists, when there are other professionals who could do that limited thing just as well really is unfortunate because it means that psychiatrists have to spend that much more of their time doing that work instead of

being engaged in patient care, and we're not making use of other professionals who are equally qualified to perform that specific function.

Siegel: Are some of these psychiatrists medically stabilizing patients in this up-to-72-hour window? And then do you see people who foreseeably won't keep taking those same medications, is that an issue in your view?

Stettin: If you're asking whether they are providing involuntary medications during that 72-hour window, there is a very specific process under state law for involuntary administration of medication. When the determination has been made that it has to happen on an emergency basis, that is to subdue a person, there is a process that allows a medical doctor to make that determination. Certainly nothing in our bill would impact that. But medications that are provided for therapeutic purposes, that is to help the person get better, cannot be provided over a person's objection without a finding in what's called a Rivers hearing that the person lacks capacity to make treatment decisions. So that's a process that the court has to get involved in, and is less likely to take place in that 72-hour window.

Honan: One question, Brian, I had, and it's just checking something that the mayor brought up a few times on Tuesday when this was announced is the use of FaceTime, or someone in the field dealing with someone who's facing a mental health crisis to determine what happens. Do you know who'll be on the other end of that FaceTime? Are they city employees? Are they contracted out? I know there's use of telehealth, telemedicine throughout the city for various purposes, but I don't know if you have any information or details on that? That has also come up from some people.

Stettin: The plan is to use clinicians who work in our H + H hospitals who would staff this.

Honan: Oh, great.

Stettin: So we're working with H + H to bring that online. And I think it's really also important to keep in mind about that telehealth line, that this is really designed... It's so ironic to me that this has been portrayed as a plan that's about getting cops involved in medical decision making when in fact this particular part of the plan that you're talking about shows how much we are trying to get clinicians involved and deemphasize the role of police. And so this is designed for the situation where a police officer encounters somebody on their patrol and there is not a co-responder team handy, there's not a clinician on the scene as we want to happen in as many cases as possible. And so that officer has been basically put in a situation where they have to potentially exercise their own authority under Section 9.41 of the mental hygiene law to make their own independent decision about whether this person seems to meet the criteria under the law.

And as you can imagine, many police officers are uneasy about making those decisions. They feel like they are not entirely qualified to decide whether somebody has appearance of a mental illness and whether they're exhibiting symptoms that suggest that they cannot meet their basic needs such that they are a danger to themselves. And this is, I think, a great phone-a-friend opportunity where a police officer can get on the phone, and potentially onto a video chat, so that

they can give that clinician at our H + H facility some visual information and get some advice. Get some expert help in figuring out whether there's enough to go on and determine whether it's possible to help this person which the officer may very much want to do.

Siegel: So we mentioned Kendra's Law in our intro, and I think this will be paneled with a question. Do you want to talk a little about that and the role that AOTs do or should play in continuum of care, and how this new plan might impact those?

Stettin: Absolutely. So Kendra's Law, assisted outpatient treatment, is a remarkably effective program when utilized. It is very specifically targeted at the subset of people with severe mental illness who have demonstrated that they have great difficulty adhering to outpatient treatment that is prescribed for them. And so consequently, we end up in this heartbreaking revolving door where they are discharged from hospitals, and connected to treatment plans, and connected to providers. Often because of anosognosia, as we talked about earlier, they tend to disengage from their treatment and repeat this horrible cycle again and again where they decompensate to the point where they wind up hospitalized. Often they wind up committing acts that get them arrested, and then they're in the clutches of the criminal justice system.

And so where we have identified this particular pattern in a person's case, by looking at their treatment history and their arrest history, we can say, "Hey, let's stop this revolving door. When we release this person from a hospital the next time, let's connect a court order to that outpatient treatment plan that really makes the system accountable to the person as well as making the person accountable to the treatment system." It's basically a mutual court order where we put ourselves on the hook as much as the individual to say, "Here's a treatment plan that the court has approved." And we have this mutual expectation that the person will stay engaged with it and that the system is going to deliver what's been promised. And it's important to note there's no punishment attached to the person's violation of this court order.

It's not about them being in trouble, it's not scary or they're going to be held in contempt of court the way we might normally associate with a court order. A person's violation of it, that is their failure to stay adherent to the treatment, simply triggers a process where we can bring that person in for an evaluation and see how they're doing a little bit sooner, a little bit more proactively than we might otherwise be able to if they were not on this court order and we were waiting around for them to exhibit signs of dangerousness to self or others. Here we can basically take into account in making that determination that this person has been told by a court that they really need this treatment to stay safe in the community. The fact that they're not adhering to it is relevant information in deciding if going to bring this person in for an evaluation.

As I said, this is a great, important, and effective program. Our frustrations with it have mostly revolved around the fact that there are people who meet these criteria who have this history of treatment non-engagement who would clearly qualify for help under Kendra's Law who are not getting it. The primary reason we've identified for that is that the hospitals are really all over the map in terms of how much they have embraced operationally screening their psychiatric inpatients for AOT eligibility.

The way it ought to work is that when a person is in on an inpatient stay, voluntary or involuntary, as part of their discharge planning there should be a consideration of whether they meet the AOT criteria based on their history. If they do, a referral should be made to our Department of Health and Mental Hygiene which operates our AOT program so that they can take the ball from there.

There are some hospitals in the city that do that routinely and others that don't. We think we can strongly increase the numbers of people who benefit from this program by requiring as part of this standard of care for hospitalized patients that there'd be this simple screening, not expanding the criteria another way, but making sure that all those who meet these exact legal criteria are referred to the program and appropriate.

Siegel: Right, thank you for taking the time to go through all of this. To me, as I'm thinking this through, you hit all of these knotty and difficult questions of consent. I think as you're working this out practically, a lot of this is you're bringing up with the different hospitals and we have these very different mechanics.

If the idea here is to stop this revolving door for severely mentally ill people between let's say streets and subways and then jails and hospitals. Like the mayor said, we can't just stabilize people over a few days and send them back out into the city, we must build a continuum of care that helps people and patients transition to step down programs and eventually into supportive housing.

Prior to building that continuum of care, I'm hoping you can use this to step back and give New Yorkers who are just maybe seeing the headlines or starting to take this in, the full picture. What is the purpose of having more people involuntarily brought in and evaluated if the state law says that they should be released once stabilized even if they're not necessarily going to take their medication then?

Stettin: Again, the point of it is compassion and care, right? It's simply a matter of saying we have an individual who right now is in an acute crisis and the first thing they need before we can go any further is to get them stabilized in a hospital. It is an absolute abdication of responsibility and a moral outrage and something we should be held accountable for when that's the end of the process for that person. When they're stabilized with medication and then turned back out on the street to repeat that cycle again is something that's intolerable. But there's no getting around the fact that when a person is in that acute crisis, that's where we start. I think what we're saying with this plan is we don't really have any options that are compassionate when we are faced with this particular situation. Let's start by getting that person hospitalized. Let's get them stabilized and then, absolutely, we have a lot of work to do to make sure that the things that need to happen from there take place.

I can tell you that we're working on that diligently and I do believe we're going to get to a great place. In the meantime, our health and hospitals corporation has committed to making sure that people who come in to the hospital in this acute crisis will stay there until they are in fact stable and will not be irresponsibly discharged. We're all working together to make sure that happens and it's an ongoing process.

Honan: Brian, thank you so much for coming on and I think really further clarifying this announcement and especially knowing that there will be more announcements coming to address this major issue, but I really appreciate you coming on.

Stettin: Absolutely, Katie, I'm so glad to have this opportunity to set the record straight in so much of the misunderstanding that has been frustrating to us in the way this has been discussed in the last few days. Thank you.

Honan: No, thank you.

Siegel: Thank you, Brian.

Stettin: Take care, guys.

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