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**New York State Senate Standing Committees
on Mental Health and Developmental
Disabilities and Health Public Hearing on
Suicide and Suicide Prevention**

**National Alliance on Mental Illness of New York State
(NAMI-NYS)**

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Good Morning. Thank you Senator Carlucci and Senator Rivera for holding today's hearing and for the opportunity to provide our insights on the important topic of suicide prevention. My name is Matthew Shapiro and I am the Associate Director, Public Affairs for the National Alliance on Mental Illness-New York State (NAMI-NYS). With me today is Roy Etere; Roy's family is one of the 1,700 New York familiesⁱ who experience the worst type of loss imaginable, that of a loved-one to suicide.

Suicide is the most unique public-health epidemic due to the multiple root causes which create many challenges to addressing and prevention. The staggering numbers speak to these challenges. Suicide is the only leading cause of death in America that continues to increase. The recent report released by Governor Cuomo's Suicide Prevention Task Force details how the rates of suicide in New York State are actually outpacing this disturbing national trendⁱⁱ, with state suicide rates increasing 29.1% from 1999 to 2016.ⁱⁱⁱ

There are no easy answers to preventing suicide, and using a strictly mental health approach will not be successful, as reforming multiple systems and incorporating true cultural competency will be needed to fully address and hopefully eliminate suicide. Since it will take a multidisciplinary approach to address suicide, an encouraging first step is to see the chairs of the Mental Health and Health committees working together on the issue.

New York and our leaders are making in-roads towards prevention. Our testimony will explain what New York is doing right and what the state is doing wrong as well as provide a road-map for further advancements towards zero suicide. NAMI-NYS believes the following actions are needed to address suicide:

1. Understanding that cultural competency must be utilized to address the multiple root causes of suicide that exist in the wide gamut of communities in New York State. This includes examining how social-economic issues factor into suicide.
2. An expansion of both in-patient and community based mental health care along with increasing psychiatric crisis services and further integration of psychiatric services in existing systems. This will not be possible without broadening the mental health workforce and ensuring insurance parity.
3. Ensure person-centered psychiatric care and access to appropriate medication.

4. Appropriate funding for mental health housing programs with wrap-around services.
5. Reform the criminal justice-mental illness interface.
6. More services to meet the psychiatric needs of our veterans.
7. More mental health literacy in schools and increased teacher training.
8. Making Kendra's Law permanent.
9. Continuing to invest in successful early-intervention programs.
10. Create a "Nicole's Law" to reform the way hospitals and psychiatric facilities treat people who engage in self-inflicted life-threatening activities.

I will explore these points by starting with the positive. We have leaders who care, and I want to commend you, Senator Carlucci, for your constant determination to eliminate suicide and congratulate you on your recent introduction and passage of bill S.4467 which would create a black youth suicide prevention task force to examine, evaluate and determine remedies for improving mental health and preventing suicides among black children, 5 to 18-years-old. As you stated in your press release on the bill, "The suicide rate for black children had an increase of 77 percent from 2006 to 2016, according the Centers for Disease Control and Prevention."^{iv} As you also stated in your release; "We have a silent crisis in our black communities among children. When suicide rates are nearly double for black youth when compared to white youth, we cannot ignore this."^v

You are 100% correct; this is a silent crisis that cannot be ignored. However, as with suicide in general, we must be careful how we break the silence around this issue. Suicide prevention is by no means a one size fits all approach. Why suicide is an outcome, differs by community. This is why it is important that we look at the root causes (including socio-economic factors) that exist in different communities as multiple unique problems require their own community focused solutions, just as people need person-centered treatment. The Governor's Task Force report also distinguishes veterans, Latinas and the LGBTQI community as "high-risk groups."^{vi} This is why we must understand and utilize cultural competency when engaging in suicide related communication and engagement.

While proper communication is important, it is also crucial to state that awareness or mental health literacy are not the sole or most effective engines to drive prevention. For far too long

stigma was blamed as the main culprit to people not seeking out and receiving mental health supports. New York has made incredible strides in changing the public's perception of mental health issues and people are now more aware than ever. However, despite this enhanced awareness we still see suicide rates increase. NAMI-NYS would argue the reason for this is there are not enough mental health services available, especially in rural and inner-urban areas.

In the April 26th edition of the New York Times, Dr. Amy Barnhorst, the vice chairwoman of community psychiatry at the University of California, Davis, wrote a very insightful opinion piece on the mistakes being made in preventing suicide. In the article she states:

“Mental health providers perpetuate the narrative that suicide is preventable, if patients and family members just follow the right steps. Suicide prevention campaigns encourage people to overcome stigma, tell someone or call a hotline. The implication is that the help is there, just waiting to be sought out. But it is not that easy. Good outpatient psychiatric care is hard to find, hard to get into and hard to pay for. Inpatient care is reserved for the most extreme cases, and even for them, there are not enough beds. Initiatives like crisis hotlines and anti-stigma campaigns focus on opening more portals into mental health services, but this is like cutting doorways into an empty building.”^{vii}

Dr. Barnhorst's comments reflect what NAMI-NYS has long argued in our advocacy and budget testimony; there are simply not enough psychiatric services available. New York has long invested in community-based mental health services by slashing inpatient services. This practice not only fails to meet the needs of people located on all points of the very broad spectrum of psychiatric disorders, it has also left us with both in-patient and out-patient services that are woefully underfunded and to the purposes of this hearing, ill-equipped to properly prevent suicide.

In December of 2018, Assembly Mental Health Chair Aileen Gunther held a hearing on the mental hygiene budget. As part of our testimony, our Government Affairs Chair, Evelyn Tropper, detailed the struggles she and her husband experience trying to locate community services for their adult daughter living with schizophrenia anywhere near their home in Lake Placid.^{viii} The Tropper's experience is one that unfortunately is not unique, as our helpline is

flooded with calls detailing struggles to locate services from people in all corners of our state. It is imperative that people with more serious types of mental illness such as schizophrenia and bipolar disorder, whose symptoms of psychosis, delusion and severe changes in mood leave them more vulnerable to suicide, are able to access appropriate support services.

In her testimony, Evelyne also detailed the additional challenges insurance providers present to access to potentially life-saving care. Evelyne explained how Medicaid typically only pays for a 10-day period for an acute psychiatric care hospital stay which led to her daughter to being prematurely discharged. Evelyne also explained how when her family could not locate a provider who took Medicaid and wanted to pay for their daughter's care out of pocket, they were informed that once sign up for Medicare/Medicaid you agree not to seek privately paid doctors. Private insurance also plays a dastardly role in this problem. On May 16th Bloomberg Businessweek published a story "As Suicides Rise, Insurers Find Ways to Deny Mental Health Coverage." In the article, Angela Kimball, NAMI's Acting CEO states; "You have parity coverage on paper, but if you can't find an in-network provider in your coverage, it can become meaningless for you if you can't afford care or find it."^{ix} Again, here is an area where New York State should be praised for establishing the Community Health Access to Addiction and Mental Health Care Project (CHAMP), to fight for New Yorkers facing insurance obstacles to treatment, to make sure anyone who seeks treatment--gets it, regardless of their ability to pay.^x

Just as crucial is the ability to access psychiatric crisis services. NAMI-NYS argues that no one should have to travel more than an hour to find psychiatric crisis services, but for many this goal is far from reality. We also need investments in Assertive Community Treatment (ACT) teams and crisis response teams that can meet people where they are during a crisis as well as crisis respite and stabilization centers.

While locating community based services can be arduous, locating in-patient services is fast becoming next to impossible as psychiatric beds continue to be reduced in both public and private hospitals. We also commonly hear stories of people with a psychiatric emergency lingering for days in emergency rooms ill-equipped to address their illness while staff struggles to locate a psychiatric bed for them. Often once a bed is located, that bed is in a different part of the state. One of our board members just had this experience with her son; they live in Otsego

County and after a long period of time in the ER, a bed was found for him, however it was located hours away in Western New York.

Moving people hundreds of miles away from their family makes family engagement, needed for successful recovery, far more difficult, creating additional issues for people more susceptible to negative outcomes such as suicide. The lack of a sufficient amount of inpatient beds has also led to questionable discharge practices. Many people are discharged before they are ready, as the bed they occupy is desperately needed. Roy will discuss the impact of pre-mature discharging during his testimony.

NAMI-NYS has argued that one way to address the lack of in-patient services is to expand the use of mental health housing programs with full wrap-around recovery focused services. These programs are tremendously valuable as they provide a safe, secure and supportive environment that can mirror the care one would receive in a hospital setting. Our Board President, Ariel Coffman, detailed the importance of mental health housing in meeting the psychiatric needs of her father when we testified earlier this year on the Governor's budget proposal.^{xi} Appropriately investing in mental health housing programs would be one proactive step in curtailing suicide.

Unfortunately, New York State has failed to make these life-saving investments. Non-profit mental health housing programs have received flat-funding for a quarter-century. When factoring in inflation, this plateau in funding has left these programs operating at 43% of where they should be under current economic conditions. Our colleagues with the Bring it Home campaign estimate that it would take \$120 million to close that gap, yet this year's budget included just \$10 million towards this purpose. As you can imagine, this has left many providers struggling and we fear that many will be forced to close their doors, thus making access all the more difficult.

Discussing the prevention of suicide without discussing the need to expand access to mental health services is a moot and deadly conversation. It is clear that the first step towards preventing suicide is making sure psychiatric care is readily available and ensuring that insurance policies cover psychiatric care the same way that physical care is covered.

One measure that has been successful in increasing access is integrating psychiatric care into primary care providers and schools, especially in areas where services are extremely limited.

There are successful examples of integrated care in primary care settings under the New York State Medicaid program. The New York State Office of Mental Health (OMH) has done good work on integrating mental health clinics in schools and in utilizing Project Teach to increase mental health services for children and adolescents. These are certainly steps in the right direction, but they are merely small steps in a long journey to eliminate suicide.

Imperative to the wide-range availability of mental health services is ensuring we have a robust mental health workforce. Unfortunately, New York State missed an opportunity to build towards this goal when this year's budget omitted a 2.9% Cost of Living Adjustment (COLA) for non-profit human services agencies. However, the New York State legislature has another opportunity to contribute to the reduction of suicide by expanding the mental health workforce who can diagnose and treat psychiatric conditions. NAMI-NYS urges your support of A4383. The bill would grant mental health licensed practitioners (LPs) and licensed mental health counselors (LMHCs) with the authority to diagnose. LMHCs and LPs are qualified and recognized psychotherapy professionals and have the education and training to diagnose mental health conditions. Their skills are desperately needed and the time is long overdue to increase the access to appropriate care by granting LMHCs and LPs with the ability to diagnose.

Insurance policies are also placing obstacles to another essential element to suicide prevention: the need for person-centered care. Psychiatric disorders impact each person differently and two people with the same diagnosis regularly have a completely different set of symptoms. This is why it is crucial to look at the person and not their diagnosis and direct their treatment accordingly. This is especially important when prescribing medication and ensuring that a doctor has the final say on what medication is best to address the individual after examining their symptoms and other medication they may be taking, this method is known as prescriber prevails.

Prescriber prevails is effective in curtailing suicide, as prescribing the wrong medicine (especially anti-depressants) can exacerbate suicidality, and drugs that treat mental illnesses are rarely interchangeable. Prescriber prevails is in constant need of protection as both the state Medicaid program and private insurance providers aim to dismantle the practice. We want to commend the legislature for constantly restoring the Governor's proposed elimination of prescriber prevails for Medicaid in the state budget. We now need you to address the threats by

private insurance providers. We urge you to support the passage of S2849/A2969, which would regulate the use of non-medical switching by insurance providers. Having the most effective drugs readily available is also paramount. This is why NAMI-NYS supports A3830, which would allow pharmacies to administer long-acting injectable anti-psychotic medications. This would make adherence much easier, thus reducing the possibility of suicide.

While I detail the many fractures in the mental health system that contribute to the alarming rates of suicide, we cannot let these figures overwhelm us into paralysis. There are solutions, and New York can be a leader in making these solutions a reality, as we can point to other strides New York State has made.

The Senate has also led the way in improving the mental illness-criminal justice interface by continually funding Crisis Intervention Teams, which train police and first-responders in how to best interact with someone in a psychiatric crisis to generate the best outcomes. The program has greatly reduced harm to police and those they are responding to, including reducing the incidents of "suicide by cop." It is important to continue reforming the criminal justice system, increase mental health courts and expand diversionary options away from incarceration (I will detail suicide rates in prison in a moment) and towards recovery. However, diversion towards recovery oriented programs can only be successful if psychiatric services exist to divert people to. As I detailed earlier there are not enough of these services.

Earlier, I mentioned how veterans are an at risk group. Once again, Senator Carlucci, I commend you and your colleagues in the Senate for fighting to continue funding New York's unique Joseph P. Dwyer Vet-to-Vet program. Peer led programs play an important part in recovery as receiving help from someone who is empathetic to your struggles is extremely beneficial, especially for veterans. The Dwyer program has helped guide countless veterans towards recovery and away from suicide. Our goal is to see the program in each county in New York.

The mental health education bill has also been tremendously beneficial. While I stated earlier that mental health literacy is not the sole engine driving recovery it still plays an important role. Providing our students with the education necessary to recognize potential mental illness in their classmates, family members or themselves and how to communicate these concerns will

undoubtedly contribute to reducing suicide. Everyone plays a role in reducing suicide, which is why it is important that all of us are taught how to be educated and supportive friends, co-workers, neighbors and family members. The tools today's students are provided with will certainly help reduce suicide for years to come.

Earlier this year, New York boldly passed the Extreme Risk Protection Orders (ERPO) or "Red Flag" law, allowing family members, friends, neighbors and teachers to petition to have weapons removed from the homes of people believed to be a danger to themselves or suicidal. This can have a tremendous impact in suicide reduction. Earlier, I quoted the New York Times article by Dr. Amy Barnhorst; in the same article, Dr. Barnhorst states, "One of the few tried-and-true strategies is reducing people's access to lethal tools, so that if they do sink into hopelessness, any attempt they make most likely won't be fatal."^{xii} The ERPO law will save lives. NAMI-NYS also applauds this law as in many situations the voice of families are silenced when it comes to psychiatric care (despite the fact that in most cases families' have a greater insight on the situation than the person with mental illness does) and ERPO is only one of a few statutes that encourages and values the insights of families.

One other statute that encourages the insights of families is Kendra's Law, New York's Assisted Outpatient Treatment (AOT) program. While some are critical of AOT programs, it is impossible to argue their success in preventing the most negative outcomes associated with psychiatric disorders, including suicide. The New York State Office of Mental Health's "Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment" determined that Kendra's Law resulted in 55% fewer recipients engaging in suicide attempts or physical harm to self.^{xiii} Every five years when Kendra's Law is due to sunset, mental health advocates debate the merits of the program. The evidence is clear: if New York State is serious about eliminating suicide, the time has come to embrace the success of Kendra's Law and make the law permanent.

While New York should be proud for introducing these life-saving measures, it is not the time to pat ourselves on the back; these successful programs should serve as a foundation for further initiatives that will help reduce suicide.

We should build on the success of CIT not only by further expanding the program but by making other advancements in criminal justice reform vis-à-vis mental health. In 2016, I stood beside you, Senator Carlucci, outside of the Sing-Sing Correctional Facility to advocate (successfully) for your bill requiring suicide prevention training for correction officers. It is long overdue to take the next step in preventing suicide in the correctional system and the Legislature has an opportunity to do just that by passing the Humane Alternative to Long Term Confinement (HALT) Bill (S.1623/A2500). The time is now to regulate and reduce the use of solitary confinement, a practice deemed torturous by the United Nations. A study published in the American Journal on Public Health that examined inmates in New York City determined that “inmates assigned to solitary were 2.1 times as likely to commit acts of self-harm during the days that they were actually in solitary confinement and 6.6 times as likely to commit acts of self-harm during the days that they were not in solitary confinement, relative to inmates never assigned to solitary confinement.”^{xiv} As you detailed at a press conference last week, HALT is not a criminal justice issue, it’s a mental health issue.

The statistics on suicide in children are alarming. According to the CDC, the rates of suicide among males aged 10-19 increased by 44% between 2007 and 2016, in females the same age the rates increased by 70% between 2010 and 2016^{xv}. This is why providing our students with mental health education is not enough, we need to provide teachers with additional skills to recognize and intervene in mental health matters. Once again, the Legislature has the opportunity to do this by passing S5704/A5313 which would mandate broad mental health training to the mandatory continuing education for teachers. This is a sensible measure considering all the figures discussed during the hearing, and we are extremely disappointed that the NYS Union of Teachers continues to protest this live-saving measure.

We also need to continue to invest and expand OnTrackNY,^{xvi} OMH’s innovative treatment program for adolescents and young adults who have begun to develop symptoms of psychosis. Early intervention programs such as OnTrackNY have the best probability of harnessing the serious psychiatric symptoms that contribute to suicide. One of the elements that have made OnTrackNY so successful is that it engages both the individual and the family. Family involvement and caretaker education are vital to both recovery and suicide prevention and they require greater emphasis and utilization.

Above in the discussion of S.4467 I mentioned the rates in black communities and it is important to note that many of the same issues that exist in those communities are mirrored in rural areas. While I am not an economist it is important to note the socio-economic factors that contribute to suicide. The Governor's report states^{xvii}:

"Paralleling national trends, suicides among New Yorkers have increased markedly during the Great Recession. Suicide rates are higher in regions experiencing long-term challenges that adversely affect individuals, families, and communities, for example, job growth stagnation and loss of wages. Those effects become apparent when comparing the rates and means of suicide deaths between nonmetropolitan and metropolitan areas. Whereas metropolitan regions of New York State saw rate increases of 27.9% from 1999 until 2012, slightly decreasing thereafter, nonmetropolitan regions have seen continued rate increases, reaching a high in 2016."^{xviii}

While I am not able to appropriately speak to the economic factors contributing to suicide in non-urban areas, one example I can point to demonstrate how this trend is playing out in New York State is the high suicide rates among those in our dairy industry. In December of 2018, NAMI-NYS participated in a conference held by *Stake Holders Team Up for Action in New York Dairy (STAND)* and I included link to a summary of the two-day meeting and other resources in the end notes as it is important to review.^{xix}

Now Roy will tell his story and explain why New York State needs to ensure effective person-centered treatment following a suicide attempt, increase family involvement and address premature discharges by enacting a "Nicole's Law."

Hello, my name is Roy Etere from Somers in Westchester County. I am a board member of NAMI Putnam. My wife Lucille, who is with me today, is also a member of NAMI Putnam. We both volunteer with the Putnam Suicide Task Force in Carmel, NY. We would like to share our story with you and ask for your support to help the severely mentally ill and prevent them from turning to suicide to stop their pain.

Our daughter, Nicole, took her own life September 19th, 2017, after suffering with a mental illness, body dysmorphia. She was 37 years old and a very vivacious woman who worked diligently in the medical field for over ten years prior to her illness. She struggled with anxiety and depression and in March, 2017 was unable to continue work. For seven months she isolated herself from family and friends only to go out to visit her doctors and therapists. She was briefly hospitalized five times after five suicide attempts from June through August of 2017.

We were helpless and tried tirelessly to get her the help she needed. The hospitals failed to provide Nicole with appropriate treatment. Missteps included giving her medication without testing her blood to see what she had in her system, keeping her for a few days and releasing with no concrete discharge plan. As a matter of fact, the first hospital released her to the streets of Manhattan in her slippers. Although medical histories were taken at each hospitalization, no collaboration was done with previous doctors/hospitals.

Nicole could have been helped if each hospital made a proper diagnosis, recognized the severity of the mental illness and collaborated with the prior hospital. It would have helped if each hospital had a specific plan to deal with someone with multiple suicide attempts, rather than put her in the general population with medication and general groups and classes.

When entering the hospital emergency room after a suicide attempt and if that person has made prior suicide attempts, that patient should be given individualized attention to determine why these multiple attempts happened and/or continue to happen. If Nicole was given therapy in addition to medication, if she were assigned an advocate to guide her through the treatment and if a proper discharge plan was put into effect, if she received follow up support after discharge to ensure she was adhering to her discharge plan, our daughter might still be here and I would not be speaking before you today.

We have a daily void in our life. We request that you create a bill that will hold the hospitals accountable and have them put in place in-depth evaluation/diagnosis, collaboration between doctors and hospitals both within the hospital and between previous hospitals where the patient was seen/treated. Create a red-flag law which will alert hospitals/doctors/social workers/psychologists that the patient experienced a previous suicide attempt and needs intensive treatment.

Please consider calling it Nicole's Law to help protect the mentally ill in all our communities and to prevent the loss of life by suicide. Thank you for listening to our story and our request. My contact information can be found at the end of the testimony and you and your colleagues can feel free to contact as me as I want to collaborate with you, not to fill the void in my family, but to ensure Nicole's experience will prevent other families from experiencing such a void, as no family should share such a loss. May we count on you to protect the most vulnerable of the mentally ill by establishing Nicole's Law?

Thank you Roy for sharing your story, I know how difficult it was reliving Nicole's experience and the system failures which led to this tragedy. The system clearly failed Nicole and the Etteres; this is why NAMI-NYS seeks to work with you in creating a "Nicole's Law," that would address treatment procedures and discharge practices for people whose hospitalizations are a result of a suicide attempt, a drug overdose or self-harm (henceforth, I will refer to these three incidents collectively as a self-inflicted life-threatening injury).

Much like Extreme Risk Protection Orders, Nicole's Law would create another red flag practice for vulnerable patients who need more specialized, intensive and potentially life-saving supports. Nicole's Law would ensure a longer inpatient stay for someone who has been hospitalized following a self-inflicted life-threatening injury. If a family member or caretaker informs the care providers that their loved one has had multiple incidents of self-inflicted life-threatening injury, the provider must obtain the previous hospital records to verify the episode(s) and for each previous episode the minimum inpatient stay would be extended. Nicole's Law would address the insurance practices that lead to premature discharges.

The provider would also have to examine what precise treatment the patient previously received to ensure not to repeat practices which failed the patient leading to another episode of self-inflicted life-threatening injury. ERPO demonstrates the value of family insights when it comes to people with serious mental illness, and Nicole's Law would mirror that by ensuring that in these cases all attempts would be made to talk to families and receive their insights on the person's mental health history and their views on what did not work in previous treatment settings. Seeking family insight would not violate HIPAA laws, as under the law medical professionals are already required to listen to families; Nicole's Law would simply encourage the underused resource.

Nicole's Law would also require enhanced discharge planning, including providing families and caretakers with resources on how to care and monitor someone with a tendency towards self-inflicted life-threatening injuries. Families would have to receive 48 hours' notice prior to a discharge; this would provide families with the ability to both meet with the staff to discuss an integration strategy and remove potentially dangerous elements from the home. Before being discharged the individual would have a detailed meeting (which would ideally include their families) to ensure they understand what is needed to recover. They would also be connected to a community-based service provider, receive priority to access services and receive a case-worker to monitor the progress for a specified time-period.

Nicole's Law would hold providers who fail to perform all the required steps under the law accountable for their failures to provide the necessary care. A successfully implemented "Nicole's Law" would address both the suicide and substance-abuse epidemics, and has the potential to save countless lives.

Thank you for your time and your willingness to address the complex epidemic of suicide. I know we have presented a lot to you today. But we encourage you to urge your colleagues to embrace the path towards prevention that we laid out for you, beginning with working towards creating the best mental health system in the country and creating a Nicole's Law to improve treatment practices. New Yorkers have always displayed the tenacity to address our biggest problems head-on and we need to do so once again in order to save lives. NAMI-NYS looks forward to working with you and your colleagues to create a more mentally healthy New York State.

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ⁱ New York State Suicide Task Force Report, April 22, 2019 Page 7

ⁱⁱ New York State Suicide Task Force Report, April 22, 2019 Page 7 states "In the first 15 years of this century, suicide rates in the U.S. population increased by 27.5%."

ⁱⁱⁱ From 6.26 to 8.08 per 100,000. CDC WISQARS 2018

^{iv} Press Release from New York State Senator David Carlucci, April 10, 2019

^v Press Release from New York State Senator David Carlucci, April 10, 2019

^{vi} New York State Suicide Task Force Report, April 22, 2019 pages 27-31

^{vii} Dr. Amy Barnhorst "the Empty Promise of Suicide Prevention" New York Times Opinion Section, April 26, 2019: <https://www.nytimes.com/2019/04/26/opinion/sunday/suicide-prevention.html?module=inline>

^{viii} Link to NAMI-NYS Testimony from December 6, 2018 hearing: <https://bit.ly/2Ytmndc>

^{ix} <https://www.bloomberg.com/news/features/2019-05-16/insurance-covers-mental-health-but-good-luck-using-it>

^x <https://oasas.ny.gov/accesshelp/right-to-treatment.cfm>

^{xi} Link to NAMI-NYS Testimony from February 7, 2019 hearing <https://bit.ly/2JLnjwW>

^{xii} Dr. Amy Barnhorst "the Empty Promise of Suicide Prevention" New York Times Opinion Section, April 26, 2019: <https://www.nytimes.com/2019/04/26/opinion/sunday/suicide-prevention.html?module=inline>

^{xiii} New York State Office of Mental Health "Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment" 2005 Page 16 <http://bit.ly/2I36qKW>

^{xiv} Am J Public Health. 2014 March; 104(3): 442-447. www.ncbi.nlm.nih.gov/pmc/articles/PMC3953781/

^{xv} https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_04.pdf

^{xvi} <https://www.ontrackny.org/>

^{xvii} New York State Suicide Task Force Report, April 22, 2019 Page 7

^{xviii} In 2016, suicides in nonmetropolitan regions reached a high of 13.46 per 100,000 population. CDC WISQARS 2018

^{xix} <https://www.nycamh.org/programs-and-services/stand.php>