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**THE COUNCIL OF THE CITY OF NEW YORK**

**COMMITTEE REPORT OF THE LEGISLATIVE DIVISION**

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**COMMITTEE ON MENTAL HEALTH, DISABILITIES, AND ADDICTION**

Hon. Linda Lee, *Chair*

**May 4, 2023**

**Mental Health Roadmap Legislative Package**

**Int. No. 1006-2023** By Council Members Bottcher, Lee, Powers, Riley, Rivera, Louis, Farías, Restler, Hanif, Hudson, Ayala, Holden, Brewer and Ung

**Title:** A Local Law to amend the administrative code of the city of New York, in relation to providing outreach and education regarding mental health services available through NYC Care and through the New York city health and hospitals corporation

**Int. No. 1018-2023** By Council Members Lee, Powers, Rivera, Bottcher, Richardson Jordan, Louis, Menin, Restler, Ayala, Brewer and Ung

**Title:** A Local Law to amend the administrative code of the city of New York, in relation to reporting on involuntary removals

**Int. No. 1019-2023** By Council Members Lee, Powers, Rivera, Bottcher, Riley, Louis, Menin, Restler, Hanif, Hudson, Ayala, Holden and Ung

**Title:** A Local Law to amend the administrative code of the city of New York, in relation to requiring the creation of a database and interactive map of outpatient mental health service providers in New York city

**Int. No. 1021-2023** By Council Members Powers, Lee, Bottcher, Schulman, Rivera, Riley, Louis, Restler, Hudson, Ayala, Holden, Ung (in conjunction with the Manhattan Borough President)

**Title:** A Local Law to amend the administrative code of the city of New York, in relation to crisis respite centers

**Int. No. 1022-2023** By Council Members Riley, Lee, Powers, Rivera, Louis, Hanif, Hudson, Ayala, Holden and Ung

**Title:** A Local Law to amend the administrative code of the city of New York, in relation to a pilot program establishing community centers for individuals with severe mental illness in high-need areas

**Res. No. 0088-2022** By Council Members Holden, Stevens, Yeger, Bottcher, Powers and Ayala

**Title:** Resolution calling upon the United States Congress to pass and the President to sign legislation to fully repeal the Institutions for Mental Diseases Exclusion from the Social Security Act to allow states to use federal Medicaid funding to provide mental health and substance use disorder treatment services to adult Medicaid beneficiaries at Institutions for Mental Diseases

**Res. No. 0583-2023** By Council Members Joseph, Lee, Rivera, Powers, Louis, Restler, Hanif, Hudson, Ayala, Holden, Brewer and Ung

**Title:** Resolution calling on New York State to subsidize the education and licensing costs of CUNY students who commit to working in the public sector in the mental health professions, which historically experience high turnover rates and staffing shortages

**Res. No. 0584-2023** By Council Members Lee, Powers, Rivera, Bottcher, Riley, Louis, Menin, Ayala, Holden, Brewer and Ung

**Title:** Resolution calling on the New York State Legislature to pass, and the Governor to sign, legislation to enter the Interstate Medical Licensure Compact, the Nurse Licensure Compact, and the Psychology Interjurisdictional Compact, to enhance the portability of medical and mental health providers to become licensed in multiple participating states.

**Res. No. 0587-2023** By Council Members Powers, Lee, Bottcher, Schulman, Rivera, Riley, Louis, Hudson, Ayala, Holden and Ung

**Title:** Resolution calling on the New York State Office of Mental Health to expand enforcement of mental health and substance use disorder insurance parity and apply for federal grants to enforce insurance parity

**Res. No. 0588-2023** By Council Members Powers, Lee, Bottcher, Schulman, Rivera, Louis, Restler, Hudson, Ayala, Holden, Brewer and Ung

**Title:** Resolution calling on New York State to reinitiate the NY/NY supportive housing program, to have both City and State coordinate on supportive housing development and contracting

**Res. No. 0589-2023** By Council Members Powers, Lee, Bottcher, Schulman, Rivera, Riley, Louis, Hudson, Ayala, Holden, Brewer and Ung

**Title:** Resolution calling on the Federal Government to ensure that calls to 988 Suicide and Crisis Lifeline program are routed based on geolocation rather than area code

**Res. No. 0592-2023** By Council Members Schulman, Powers, Lee, Rivera, Riley, Louis, Restler, Hudson, Ayala, Holden, Brewer and Ung

**Title:** Resolution calling on the New York State and Federal governments to expand the availability of mental health professionals for low and moderate income New Yorkers by increasing Medicaid reimbursement rates for behavioral health services

1. **INTRODUCTION**

On May 4, 2023, the Committee on Mental Health, Disabilities, and Addiction, chaired by Council Member Linda Lee, will hear legislation from the Mental Health Roadmap,[[1]](#footnote-2) which includes: Introduction Number 1006-2023, sponsored by Council Member Bottcher, in relation to providing outreach and education regarding mental health services available through NYC Care and through the New York city health and hospitals corporation (Int. No. 1006); Introduction Number 1018-2023, sponsored by Council Member Lee, in relation to reporting on involuntary removals (Int. No. 1018); Introduction Number 1019-2023, sponsored by Council Member Lee, in relation to requiring the creation of a database and interactive map of outpatient mental health service providers in New York city (Int. No. 1019); Introduction Number 1021-2023, sponsored by Council Member Powers, in relation to crisis respite centers (Int. No. 1021); Introduction Number 1022-2023, sponsored by Council Member Riley, in relation to establishing community centers for individuals with severe mental illness in high-need areas (Int. No. 1022).

The Committee will also hear resolutions from the Mental Health Roadmap, which includes: Resolution Number 0088-2022, sponsored by Council Member Holden, calling upon the United States Congress to pass and the President to sign legislation to fully repeal the Institutions for Mental Diseases Exclusion from the Social Security Act to allow states to use federal Medicaid funding to provide mental health and substance use disorder treatment services to adult Medicaid beneficiaries at Institutions for Mental Diseases (Res. No. 88); Resolution Number 0583-2023, sponsored by Council Member Joseph, calling on New York State to subsidize the education and licensing costs of CUNY students who commit to working in the public sector in the mental health professions, which historically experience high turnover rates and staffing shortages (Res. No. 583); Resolution 0584-2023, sponsored by Council Member Lee, calling on the New York State Legislature to pass, and the Governor to sign, legislation to enter the Interstate Medical Licensure Compact, the Nurse Licensure Compact, and the Psychology Interjurisdictional Compact, to enhance the portability of medical and mental health providers to become licensed in multiple participating states (Res. No. 584); Resolution Number 0587-2023, sponsored by Council Member Powers, calling on the New York State Office of Mental Health to expand enforcement of mental health and substance use disorder insurance parity and apply for federal grants to enforce insurance parity (Res. No. 587); Resolution Number 0588, sponsored by Council Member Powers, calling on New York State to reinitiate the NY/NY supportive housing program, to have both City and State coordinate on supportive housing development and contracting (Res. No. 588); Resolution Number 0589-2023, sponsored by Council Member Powers, calling on the Federal Government to ensure that calls to the 988 Suicide and Crisis Lifeline program are routed based on geolocation rather than area code (Res. No. 589); and Resolution Number 0592-2023, sponsored by Council Member Schulman, calling on the New York State and Federal governments to expand the availability of mental health professionals for low and moderate income New Yorkers by increasing Medicaid reimbursement rates for behavioral health services (Res. No. 592).

Among those invited to testify are representatives from the New York City Department of Health and Mental Hygiene (DOHMH), New York City Mayor’s Office of Community Mental Health (OCMH), and advocates and community-based organizations, and other interested parties.

1. **BACKGROUND**

According to an October 2022 survey by CNN, in partnership with the Kaiser Family Foundation, an overwhelming majority of Americans – 9 out of 10 adults – believe that the country is experiencing a mental health crisis.[[2]](#footnote-3) The World Health Organization defines mental health as “a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn and work well, and contribute to their community.[[3]](#footnote-4) The Centers for Disease Control and Prevention (CDC) characterizes mental health as fundamental to emotional, psychological, and social wellbeing at every life stage.[[4]](#footnote-5) In the United States (U.S.), more than 50 percent of the population are diagnosed with a mental illness or disorder at some point in their life.[[5]](#footnote-6) In a given year, 1 in 5 Americans will experience a mental illness, and 1 in 5 children – either currently or at some point during their life – have had a seriously debilitating mental illness.[[6]](#footnote-7) Further, 1 in 25 Americans are living with a serious mental illness (SMI), such as schizophrenia, bipolar disorder, or major depression.[[7]](#footnote-8)

In New York City, COVID-19 has had a substantial impact on the mental health of New Yorkers of all ages, especially low-income, immigrant, and Black and Brown communities. According to data reported in April 2021, nearly 1 in every 25 New Yorkers is living with a diagnosed SMI.[[8]](#footnote-9) Around 280,000 adults in New York City have a SMI, such as schizophrenia or major depressive disorder accompanied by substantial functional impairment.[[9]](#footnote-10) This is an increase from 2012, in which approximately 239,000 (4 percent) had a diagnosed SMI.[[10]](#footnote-11) In New York City in 2015, the prevalence of SMI in Whites (5 percent) and Hispanics (7 percent) was higher than the prevalence of SMI in Blacks (1 percent) or Asians (1 percent).[[11]](#footnote-12) While these prevalence differences are similar to those in national findings, it is important to note that Black New Yorkers have been found to have higher hospitalization rates for mental illness despite lower prevalence of a lifetime diagnosis.[[12]](#footnote-13) According to OCMH, the highest poverty neighborhoods have over twice as many psychiatric hospitalizations per capita as the lowest poverty neighborhoods in NYC.[[13]](#footnote-14)

1. **NEW YORK CITY COUNCIL’S MENTAL HEALTH ROADMAP**

On April 24, 2023, New York City Council Speaker Adrienne Adams and Chair Linda Lee announced the Mental Health Roadmap (“the Roadmap”), a plan focused on addressing existing challenges in New York City’s mental healthcare landscape and strengthening the infrastructure of and investments in evidence-based solutions to help improve mental health outcomes for all New Yorkers.[[14]](#footnote-15) The Roadmap is a continuously evolving plan that recognizes the priorities of New Yorkers on the ground and addresses barriers to improve mental healthcare in New York City, with a focus on four key areas: (1) expanding prevention and supportive services in communities; (2) investing in the mental health workforce that has diminished because of inadequate support; (3) confronting the harmful intersections between mental health and the criminal justice system to connect New Yorkers with appropriate care; and (4) bolstering public awareness of care resources and improved interagency coordination.[[15]](#footnote-16)

* 1. **Mental Health Prevention and Supportive Services**

In a study by Cohen Veterans Network and the National Council for Mental Wellbeing that assessed Americans’ current access to and attitudes towards mental health services, it was revealed that despite high demand, the root of the problem is a lack of access – or the ability to find care.[[16]](#footnote-17) There is a particular lack of access to affordable, culturally sensitive care within Black and Brown communities and other communities of color.[[17]](#footnote-18) In New York City, 91 percent of residents in the Bronx insured by Medicaid live in a mental health desert,[[18]](#footnote-19) and most of whom identify as Black, Brown, or low income New Yorkers.[[19]](#footnote-20) According to the U.S. Health and Human Services Office of Minority Health, Black Americans living below the poverty level are twice as likely to report psychological distress as those over twice the poverty level, yet less than half of Black adults who need care for serious conditions receive it.[[20]](#footnote-21)

The lack of mental health access in certain communities is deep and extends beyond just a lack of providers.[[21]](#footnote-22) Communities of color are far more likely to be under- or uninsured than their white counterparts, which decreases access to affordable mental healthcare.[[22]](#footnote-23) They are also less likely to receive culturally sensitive, trauma-informed care, which is crucial to building trust between providers and communities.[[23]](#footnote-24) Without access to culturally sensitive and sustained mental healthcare in communities, mental health emergencies involving hospitalization – and in many cases law enforcement – will continue to cause suffering, especially within communities of color.[[24]](#footnote-25) For example, in 2022 there were 345,598 “Emotionally Disturbed Person” (EDP)[[25]](#footnote-26) calls for service throughout New York City – the map below shows the number of calls made in each borough, with the darkest blue showing up to 18,000 calls and the lightest blue showing 4,000 or fewer calls:



Source: NYC Council Data Unit

According to the above map, Manhattan received the highest number of EDP calls (94,753), with Brooklyn a close second (91,743), followed by the Bronx (78,673), Queens (65,704), and Staten Island with the lowest (14,718). The map also shows the locations of Clubhouses[[26]](#footnote-27) (red dots) and DOHMH-affiliated Crisis Respite Centers[[27]](#footnote-28) (blue dots). Clubhouses are evidence-based models of psychiatric rehabilitation that provide one-stop places that help people with SMI by providing peer support, access to services, employment and educational opportunities, and socialization and recreation in a safe, restorative, and structured setting.[[28]](#footnote-29) Research shows that this model reduces hospitalization and justice involvement for individuals with SMI.[[29]](#footnote-30) While Crisis Respite Centers provide an alternative to hospitalization for individuals experiencing acute emotional crises.[[30]](#footnote-31) Thirty-five Council districts do not contain a Crisis Respite Center or a Clubhouse, while the districts with the highest number of EDP calls in 2022 are District 3 (18,404), District 17 (14,044), District 9 (13,593), and District 8 (13,430).

* 1. **Mental Health Workforce Shortage**

According to recent survey data from the National Council for Mental Wellbeing, the vast majority of the nation’s behavioral health workforce[[31]](#footnote-32) (83 percent) believes that without public policy changes, provider organizations in the U.S. will not be able to meet the current demand for mental health treatment and care due to a severe mental health and behavioral health workforce shortage.[[32]](#footnote-33) Around 9 in 10 behavioral health workers are concerned about the ability of those not receiving care to access it.[[33]](#footnote-34) Nearly 2 in 3 reported an increase in client caseload, and more than 7 in 10 reported increased client severity since the COVID-19 pandemic.[[34]](#footnote-35) Further, more than 9 in 10behavioral health workers said they have experienced burnout, with nearly half of such workers saying the impacts of workforce shortages have caused them to consider other employment options.[[35]](#footnote-36) In New York City, this also translates to workforce shortages in certain communities.

The following table shows the breakdown of the number of providers in each county in New York City per 100,000 residents:[[36]](#footnote-37)

|  |  |  |
| --- | --- | --- |
| **County** | **Number of Mental Health Providers per 100,000 residents** | **Total Estimated Population**  |
| Queens | 48.8 | 2,270,976 |
| Kings | 64.6 | 2,576,771 |
| Bronx | 59.8 | 1,427,056 |
| New York | 377.4 | 1,629,153 |
| Staten Island | 65.8 | 475,596 |

Source: ABC OTV analysis of federal government’s healthcare provider database

As shown above, there is a large disparity in the number of providers in Queens County, Kings County, Bronx County, and Staten Island compared to New York County (i.e. Manhattan). According to the most recent census data, Black/African Americans make up one of the largest residential populations in both the Bronx and Brooklyn, while Asians/Asian Americans make up the largest portion of the residential population in Queens.[[37]](#footnote-38) New York County, on the other hand, has the largest population of white residents out of the 4 listed above.[[38]](#footnote-39) There is clearly a lack of access to affordable, culturally sensitive care within Black and Brown communities and other communities of color in New York City.[[39]](#footnote-40) Despite Queens and Kings County having the highest total estimated populations (which are primarily Black, Brown, and Asian), those areas have less than half the number of mental health providers per 100,000 residents combined compared to New York County.

Growing the mental health workforce in communities of color requires sustained educational and outreach efforts, federal student loan forgiveness, better guarantees of federal insurance parity and livable wages for mental health workers, and increased efforts to incentivize Americans of color to attend and have access to mental health training and graduate programs.[[40]](#footnote-41) Without access to culturally sensitive, affordable, and sustained mental healthcare within communities of color, mental health emergencies will continue to occur disproportionately in communities of color, and individuals will continue to suffer from treatable mental illnesses.[[41]](#footnote-42)

* 1. **Mental Health’s Intersection with Criminal Justice System**

The number of individuals diagnosed with SMI in the U.S. criminal justice system has reached unprecedented levels.[[42]](#footnote-43) Most county jails in the U.S. have 3 times as many people with SMI than would be expected from community-based estimates.[[43]](#footnote-44) According to the National Alliance on Mental Illness (NAMI), between 25 percent and 40 percent of all mentally ill Americans will be jailed or incarcerated at some point in their lives, compared to 6.6 percent of the general population.[[44]](#footnote-45) Further, 8 percent of individuals incarcerated with mental illnesses have an arrest that is directly attributable to symptoms of psychosis.[[45]](#footnote-46) And even though Black and Brown individuals are more likely to be involved in the criminal justice system, there is evidence that they are less likely to be identified as having a mental health problem and less likely to receive access to treatment once incarcerated.[[46]](#footnote-47)

 SMI has become so prevalent in the U.S. corrections system that jails and prisons are now commonly called “the new asylums.”[[47]](#footnote-48) Overall, approximately 20 percent of inmates in jails and 15 percent of individuals incarcerated in state prisons are now estimated to have a SMI.[[48]](#footnote-49) Based on the total incarcerated population, this means approximately 383,000 individuals with severe psychiatric disease were behind bars in the U.S. in 2014, or nearly 10 times the number of patients remaining in the nation’s state hospitals.[[49]](#footnote-50)In New York City, Riker’s Island Jail holds more mentally ill individuals than any remaining psychiatric hospital in the U.S.[[50]](#footnote-51) From 2005 to 2012, the average daily population at Riker’s Island actually dropped 12 percent, but the prevalence of mental illness *rose* by 32 percent.[[51]](#footnote-52) Without adequate capacity of more intensive psychiatric care at hospitals and access to in-community holistic care, individuals with mental illness are unlikely to break free of the hospitalization-discharge-arrest-incarceration cycle that disproportionally affects Black and Brown New Yorkers with mental health disorders.

* 1. **Mental Health Public Awareness and Interagency Coordination**

Community-based mental healthcare is only accessible to communities when there is public awareness of what is actually available. Mental health awareness initiatives are critical in that they can help those who are suffering understand how the symptoms of mental health disorders manifest, allowing them to seek treatment before their condition worsens and prevents significant disruptions to their social or work life.[[52]](#footnote-53) Research also shows that when people have better knowledge of different types of mental illness, they are significantly less likely to hold discriminatory views towards others with mental illness.[[53]](#footnote-54) Cultural stigmas and negative perceptions about mental health can discourage individuals from getting help, which only stresses the importance of effective public awareness and education. Attitudes about mental health issues vary among different communities: both religious ideas and cultural perceptions can shape how people feel about getting mental healthcare.[[54]](#footnote-55) Thus, understanding different cultural perceptions about mental health is key to developing culturally sensitive programs and services that are accessible to all members of a community.[[55]](#footnote-56)Achieving a comprehensive, efficient, and culturally-competent mental healthcare infrastructure requires the coordination of private, nonprofit, and public actors in the provision of mental healthcare and services, and providing the public with culturally appropriate and linguistically diverse resources to access necessary services.[[56]](#footnote-57)

1. **BACKGROUND ON RESOLUTIONS**

Although most mental health services are in an outpatient setting, treating some SMIs requires a hospital or inpatient psychiatric care.[[57]](#footnote-58) Inpatient treatment may be provided in a general hospital unit or a specialized psychiatric hospital – within the Medicaid context, specialized psychiatric hospitals are known as “Institutions for Mental Diseases,” or IMDs.[[58]](#footnote-59) Federal law generally prohibits IMDs from billing Medicaid for care to adults between the ages of 21 and 64 at a facility with more than 16 beds.[[59]](#footnote-60) Recently, interest in repealing the IMD Exclusion has increased in response to concerns over bed shortages for individuals with SMI and persistent challenges with mental illness-related homelessness and incarceration.[[60]](#footnote-61) The IMD Exclusion has existed since Medicaid was enacted in 1965, and the intent was to prevent states from transferring mental health costs to the federal government and to encourage investments in community services.[[61]](#footnote-62) The IMD Exclusion thus contributed heavily to deinstitutionalization.[[62]](#footnote-63)In recent years, various advocates and providers of mental health services have publicity supported repealing this exclusion, mainly because it was “created for an entirely different mental health landscape.”[[63]](#footnote-64) At the time of its creation, the majority of the mental health system involved long-term inpatient psychiatric hospital stays, while today, the U.S. has a wider variety of community mental health treatment options.[[64]](#footnote-65) But certain individuals with SMI may still require inpatient hospital stays, and cannot access this care – in part - because the IMD exclusion dramatically reduces access to psychiatric beds.[[65]](#footnote-66) As a result, individuals in need of inpatient care end up repeatedly in emergency departments of general hospitals, “boarded” for lack of access to available beds, and overrepresented among the homeless and incarcerated populations.[[66]](#footnote-67)

Regarding the mental health workforce shortage, according to the American Psychological Association, in 2018, about 84 percent of psychologists in the U.S. workforce were white and fewer than 15 percent were from other racial and ethnic groups.[[67]](#footnote-68) This means that individuals often see mental health providers that do not have shared racial, ethnic, language, religious, or cultural experiences, all of which can influence the quality and effectiveness of the care they receive. [[68]](#footnote-69) Culturally sensitive providers often have particular skills, such as language ability, cultural knowledge, and experience treating the special healthcare needs of the diverse communities in New York City.[[69]](#footnote-70) Culturally competent care creates stronger patient engagement, empathy, and trust.[[70]](#footnote-71) This trust and engagement are especially crucial in relationships in behavioral health to communicate and connect with disordered thoughts, moods, or other behaviors that can affect everyday function.[[71]](#footnote-72) If a network lacks providers of color, its members of color may find it more difficult to obtain services from an appropriate, competent, or conveniently located provider.[[72]](#footnote-73) The Council of Graduate Schools (CGS) stresses that supporting diversity and inclusion in graduate education is both an “economic and moral imperative.”[[73]](#footnote-74) But to accelerate this process, CGS asserts that universities, funding bodies, and policy makers must work together to develop policies and practices that help attract, retain, and support the success of all students, and especially those from populations historically underrepresented in graduate education.[[74]](#footnote-75) Developing more robust apprenticeship programs and student loan forgiveness programs may help reduce the challenges in the mental health and substance use field created by workforce shortages.[[75]](#footnote-76)

The Interstate Medical Licensure Compact (IMLC) is a legally binding agreement between 2 or more states and establishes a formal, legal relationship to address common problems or to promote a common agenda.[[76]](#footnote-77) Compacts are a flexible policy tool used to address issues where states have a need to coordinate.[[77]](#footnote-78) In recent years, the growth of telemedicine and other technologies has created new opportunities to increase access to healthcare for patients in underserved or rural areas and to allow them to connect more easily with medical experts: physicians are increasingly able to use telemedicine to practice in multiple states.[[78]](#footnote-79) The IMLC creates a voluntary, expedited pathway to state licensure for physicians who want to practice medicine in multiple states.[[79]](#footnote-80) Eligible physicians can qualify to practice medicine in multiple states by completing just one application, and thus the overall process of gaining a license is significantly streamlined.[[80]](#footnote-81) Only states who have formally joined can participate in this streamlined licensure process, and in order to participate, states must pass legislation authorizing it.[[81]](#footnote-82)

Similarly, the Nurse Licensure Compact (NLC) is an interstate agreement that allows nurses to have one license issued by their home state that they can use to practice in any state that is s a member of the NLC.[[82]](#footnote-83) Under the NLC, a nurse holding a multistate license can practice telehealth in all NLC-member states without needing a separate nursing license in each state.[[83]](#footnote-84) The NLC also facilitates online nursing education: because nursing faculty generally are required to hold a nursing license in each state in which they have students, the NLC significantly eases the burdens on schools and nursing faculty who are able to acquire a multistate license issued by their home state.[[84]](#footnote-85) Lastly, the Psychology Interjurisdictional Compact (PSYPACT) is an interstate agreement designed to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state boundaries.[[85]](#footnote-86) It allows a practitioner to practice either in the PSYPACT member states using a multistate license or by obtaining a “compact privilege or compact authorization.”[[86]](#footnote-87) PSYPACT is designed to allow licensed psychologists to practice of telepsychology and conduct temporary in-person face-to-face practice of psychology across state boundaries legally and ethically without necessitating that an individual become licensed in every state to practice.[[87]](#footnote-88) Through PSYPACT, consumers have greater access to care, and allows licensed psychologists to provide continuity of care as clients/patients relocate.[[88]](#footnote-89) Psychologists will also be able to reach populations that are currently underserved, geographically isolated, or lack specialty care.[[89]](#footnote-90) States have an external mechanism that accounts for all psychologists who may enter their state to practice telepsychology or conduct temporary in-person, face-to-face practice, thus indicating psychologists have met defined standards to practice in other states.[[90]](#footnote-91)

Regarding the enforcement of insurance parity, Timothy’s Law in New York State requires healthcare insurance policies and Health Maintenance Organization (HMO) health contracts written in New York to include benefits for the treatment of mental illness.[[91]](#footnote-92) In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA).[[92]](#footnote-93) MHPAEA and its implementing regulations prohibit health plans that offer mental health or substance use disorder (MH/SUD) benefits from imposing any financial requirement or treatment limitation that is more restrictive than the financial requirements and treatment limitations imposed upon medical and surgical benefits under the same plan.[[93]](#footnote-94) The federal law applies only to large employers with more than 50 employees; small employers with 50 employees or less are not covered by the federal parity law, but are covered by Timothy’s Law.[[94]](#footnote-95) In 2018, New York State passed the Mental Health and Substance Use Disorder Parity Report Act, which requires health plans to implement formal parity compliance plans along with regular reporting to the state.[[95]](#footnote-96) This legislation directs the Department of Financial Services to collect data from insurers on rates of utilization review, prior or concurrent authorization, adverse determinations, percentage of claims paid on an in-network and out-of-network basis, and network adequacy to determine compliance with federal and state parity laws.[[96]](#footnote-97) The data is then analyzed and used to prepare regular compliance reports.[[97]](#footnote-98) The 2019-20 New York State Budget also included an overhaul of the State Insurance Law to eliminate discrimination in coverage of care and treatment for behavioral health conditions.[[98]](#footnote-99) These new provisions, called Behavioral Health Insurance Parity Reforms (BHIPR), include coverage for all mental health conditions, substance use disorders and autism spectrum disorders.[[99]](#footnote-100)

Despite significant gains over many years, the struggle for parity is not over. Inequities in reimbursement and utilization review for behavioral health services continue to negatively impact access to care. In New York State, the Attorney General has engaged in multiple parity lawsuits, settlements, and negotiations with insurance companies: [[100]](#footnote-101)

(1) negotiated a $13.6 million payout to consumers who were denied outpatient psychotherapy by UnitedHealthcare;

(2) determined that MVP violated parity laws by imposing stricter utilization review for behavioral health services, and required specific remediation activities and fined the plan $300,000;

(3) determined that Emblem Health violated parity laws by imposing stricter utilization review for behavioral health services, and required specific remediation activities and fined the plan $1.2 million;and lastly,

(4) determined Beacon Health Options violated parity laws, and required specific remediation activities and fined the plan $900,000.

Thus, even though we now have powerful and comprehensive federal and state laws requiring parity, the fight for parity continues on a new front – full implementation and enforcement of the rules already in place.

In terms of housing, research has shown that those experiencing homelessness tend to use healthcare services – particularly high-cost services such as emergency department visits and psychiatric hospitalizations – more frequently than those not experiencing homelessness.[[101]](#footnote-102) Permanent supportive housing (PSH) is a program model that provides long-term stable housing with access to support services to promote housing stability for those experiencing chronic homelessness and been diagnosed with an SMI.[[102]](#footnote-103) The majority of studies and evaluations concluded that some, if not all, of PSH program costs are offset by savings from the reduced use of costly health services.[[103]](#footnote-104) PSH leads to greater housing stability compared to other models and contributes to improvements in mental and physical health and substance use behavior.[[104]](#footnote-105) New York State and New York City have jointly financed more than 14,000 supportive housing units via PSH agreements since 1990.[[105]](#footnote-106) In 2005, the State and New York City committed to creating 9,000 new PSH units by June 2016 for individuals experiencing chronic homelessness with complex medical and behavioral health issues, in an agreement called New York/New York III (NY/NY III).[[106]](#footnote-107) The initiative aimed to provide subsidized housing and access to support services for the most vulnerable homeless New Yorkers and reduce the costly use of emergency, psychiatric, and inpatient care services.[[107]](#footnote-108) NY/NY III followed the Housing First (HF) model, which placed as few entry requirements as possible on individuals in need of housing, meaning sobriety, treatment compliance, and criminal records would not affect eligibility.[[108]](#footnote-109)

According to the Coalition for the Homeless, the “effectiveness of the model is indisputable,” because in the first 5 years of the agreement, chronic homelessness among adults reduced by 47 percent and “more than three-quarters of the homeless people moving into supportive housing were still stably housed after two years.”[[109]](#footnote-110) Studies show that participants placed in housing through NY/NY III also utilized the available services, with nearly two-thirds of residents having participated in support groups, day treatments, or social activities, and 30 percent and 21 percent reporting to have engaged in educational or occupational activities, respectively.[[110]](#footnote-111) Placement in NY/NY III yielded statistically significant cost savings per person after one year of living in supportive housing, likely due to reduced emergency department visits and lengths of stay in hospitals and psychiatric facilities among placed versus unplaced individuals.[[111]](#footnote-112) And in December 2013, DOHMH concluded that NY/NY III supportive housing “generated annual net savings of 10,100 dollars per person.”[[112]](#footnote-113) Butrather than enter into a new NY/NY agreement, in 2015-16 the State and New York City each announced separate supportive housing commitments. New York City’s program committed to creating 15,000 supportive units over 15 years (NYC 15/15), while New York State’s plan committed to creating 20,000 supportive units statewide over 15 years (Empire State Supportive Housing Initiative, or ESSHI).[[113]](#footnote-114)

In 2020, Congress designated the new 988 dialing code, operated through the existing National Suicide Prevention Lifeline, as a “first step towards transformed crisis care system in the U.S.”[[114]](#footnote-115) While the 988 Lifeline is accessible nationally, with a national network of call centers, it essentially functions as a state-run system, and states vary vastly in how much they have invested in the former 10-digit Lifeline and associated services.[[115]](#footnote-116) According to an analysis by the NAMI, very few states have passed legislation to supplement the recent federal funds into 988.[[116]](#footnote-117) The 988 hotline holds promise toward decriminalizing the response to mental health emergencies. Currently, if an individual is experiencing a mental health crisis, they, their caregivers, and bystanders have few options beyond calling 911.[[117]](#footnote-118) As a result, roughly one in 10 individuals with mental health disorders have interacted with law enforcement prior to receiving psychiatric care, and 10 percent of police calls are for mental health emergencies.[[118]](#footnote-119)

Currently, 988 automatically routes calls by area code to the nearest crisis center based on the area code of the caller’s phone number.[[119]](#footnote-120) According to Vibrant Emotional Health, most callers to the Lifeline use mobile devices to contact the service.[[120]](#footnote-121) Some organizations consider location-based routing as essential to connect callers to the crisis center nearest them. Nearly 1 percent of callers at imminent risk of suicide are unable or unwilling to collaborate with counselors to provide their location, and serious harm or death could result if emergency services cannot locate them.[[121]](#footnote-122) As part of the 2020 Designation Act, the Federal Communications Commission (FCC) submitted a report examining the feasibility and cost of including an automatic dispatchable location with a 988 call.[[122]](#footnote-123) The FCC held a 988 Geolocation Forum in May 2022 and the agency is actively analyzing the information gathered during that forum, including whether potential routing improvements could help callers to 988 connect to the regional call centers where they are located without sharing specific geolocation information.[[123]](#footnote-124)

Lastly, behavioral health conditions (i.e. mental health and substance use disorders) are most prevalent in Medicaid enrollees, with data from 2020 showing that approximately 39 percent of Medicaid enrollees were living with a mental health or substance use disorder.[[124]](#footnote-125) Workforce challenges are widespread and go beyond Medicaid, but shortages may be exacerbated due to the fact that, on average, only 36 percent of psychiatrists accept new Medicaid patients – lower compared to other payers and compared to rates for physicians overall (71 percent).[[125]](#footnote-126) Even when providers do accept Medicaid, they may only take a few patients at a time.[[126]](#footnote-127) Lower Medicaid payment rates (relative to other payers) as well as disparities in pay between physical and mental health providers have limited providers’ overall participation in Medicaid and thus further exacerbated the workforce shortages.[[127]](#footnote-128) Psychiatrists, for example, receive lower Medicaid reimbursement than primary care providers for similar services.[[128]](#footnote-129) States have considerable flexibility to set provider payment rates in fee-for-service: managed care plans, which now serve most Medicaid beneficiaries, are responsible under their contracts with states for ensuring adequate provider networks and setting rates to providers, but states have several options to ensure that rate increases are passed to the providers that contract with managed care organizations.[[129]](#footnote-130) For one, the American Rescue Plan Act (ARPA) gave states temporary funding (primarily through an increase in the Medicaid match rate for home and community based services) to increase certain provider rates or provide payments to attract or retain workers.[[130]](#footnote-131) And the COVID-19 Medicaid public health emergency (PHE) authorities gave states additional flexibility to adopt temporary rate increases.[[131]](#footnote-132)

1. **LEGISLATIVE ANALYSIS**
	1. **Int. No. 1006-2023**

Int. No. 1006, sponsored by Council Member Erik Bottcher, would require DOHMH, in consultation with OCMH and NYC Health + Hospitals, to establish and implement an outreach and education campaign regarding mental health services that can be accessed under NYC Care.

NYC Care is a healthcare access program that guarantees low-cost and no-cost services offered by NYC H+H to New Yorkers who do not qualify or cannot afford health insurance based on federal guidelines.[[132]](#footnote-133) It is the most comprehensive initiative in the nation to guarantee healthcare, regardless of immigration status or ability to pay.[[133]](#footnote-134) To become a NYC Care member, you must (1) live in the 5 boroughs of New York City; (2) must not qualify for any health insurance plan available in New York State; and (3) not be able to afford health insurance based on government guidelines.[[134]](#footnote-135) Members may choose their own primary care provider, receive preventative care such as vaccinations, routine screenings, and mammograms, and can receive mental health support and substance abuse services.[[135]](#footnote-136) NYC Care provides access to “high-quality mental health and substance abuse services,” but one must be referred to mental and behavioral health specialists (i.e. social worker, therapist, or psychiatrist) through a primary care provider.[[136]](#footnote-137)

* 1. **Int. No. 1018-2023**

Int. No. 1018, sponsored by Council Member Lee, would require DOHMH, in conjunction with the New York City Police Department and other agencies, to provide an annual report to the Council with information regarding involuntary removals conducted pursuant to the State’s Mental Hygiene Law Sections 9.41 and 9.58. On November 29, 2022, Mayor Eric Adams announced his plan to provide care for New Yorkers suffering from untreated SMI, which included a directive regarding involuntary removal and hospitalization of individuals with SMI.[[137]](#footnote-138) The announcement included an 11-point psychiatric crisis care agenda aimed at changes that should be made at the state level and discusses barriers to psychiatric crisis care and avoidance.[[138]](#footnote-139) The press release from the Mayor stated that outreach workers, city-operated hospitals, and first responders would provide care to New Yorkers when SMI prevents them from meeting their own basic human needs to the extent that they are a danger to themselves.[[139]](#footnote-140) The mayor’s directive instructs police and medical workers to assess people in public spaces on a “case by case” basis to see whether they were able to “provide basic needs such as food, shelter and healthcare for themselves.”[[140]](#footnote-141) However, advocates are concerned that individuals will be removed but merely because they are homeless.[[141]](#footnote-142)

Individuals with SMI are at risk from encounters with law enforcement, and the results of such encounters are often deadly, especially when the person with a SMI is Black or Brown.[[142]](#footnote-143) Notably, nationwide, law enforcement officers are generally the first and only responders dispatched when individuals with SMI experience a crisis or otherwise need help, or reported for “disturbing or annoying others.”[[143]](#footnote-144) The same is true for autistic people, individuals with substance use issues, and individuals with intellectual or developmental disabilities.[[144]](#footnote-145) The Administration has stated that they will provide “vignettes” in training and guidance materials for law enforcement, which will be representative of fact patterns in case law and demonstrate what the “failing to meet basic survival needs” standard looks like in practice. The Administration has specified that things to look out for include disorientation, untreated “open wounds,” or bare feet. However, advocates are concerned that such standard will not be applied equitably, and only exacerbate the systematic inequalities that already pervade the justice and mental health system.

* 1. **Int. No. 1019-2023**

Int. No. 1019, sponsored by Council Member Lee, would require DOHMH to develop and maintain a searchable electronic database and interactive map of outpatient mental health service providers in New York City, allow providers to submit requests for inclusion in the database and interactive map, and provide specific information on each mental health service provider.

* 1. **Int. No. 1021-2023**

Int. No. 1021, sponsored by Council Member Powers, would require DOHMH, in conjunction with OCMH, to ensure that each borough has at least 2 Crisis Respite Centers (CRCs) in operation, which are open to walk-ins and referrals, and afford individuals with SMI accessible treatment and resources within their communities and as alternatives to hospitalization. In New York City, there are currently 4 DOHMH-affiliated CRCs[[145]](#footnote-146) in operation: 1 in Manhattan, 1 in the Bronx, 1 in Brooklyn, and 1 in Queens.[[146]](#footnote-147) CRCs provide an alternative to hospitalization for individuals aged 18 or 21 and over who are experiencing an emotional or mental health crisis.[[147]](#footnote-148) Stays at these centers are voluntary and can typically last for up to 7 days.[[148]](#footnote-149) A critical aspect of CRCs is the “warm, safe and supportive home-like” atmosphere with an open door policy so clients can continue their daily activities.[[149]](#footnote-150) CRCs offer services such as 24-hour peer support, self-advocacy education, self-help training, social support groups, recreational activities, and linkage to medical and psychiatric providers.[[150]](#footnote-151) CRCs are licensed and regulated pursuant to the State’s Office of Mental Health (OMH) regulations, and for adults aged 21 and over, Medicaid reimbursement for the Crisis Residence Component (i.e., services provided by CRCs) of the Crisis Intervention Benefit is only available through Medicaid Managed Care Plans, which reimburse the OMH-licensed providers.[[151]](#footnote-152) However, as previously discussed, lack of access is clear, evidenced by the fact that there is 1 CRC located in the Bronx, where 91 percent of residents insured by Medicaid are living in a mental healthcare desert. And due to the low number of CRCs, there is limited capacity to the number of individuals each CRC can serve, with 1 CRC reporting having an extensive waiting list of individuals wanting to utilize CRC services.[[152]](#footnote-153)

* 1. **Int. No. 1022-2023**

Int. No. 1022, sponsored by Council Member Riley, would require DOHMH, in consultation with OCMH, to create a program that would establish more community centers for individuals with SMI (i.e., clubhouses) in high-need areas of New York City. A “clubhouse” for individuals with SMI is a psychosocial rehabilitation model that comprises nonclinical, integrated therapeutic working communities for individuals with SMI.[[153]](#footnote-154) The model’s hallmark is that it is community-based and designed to support recovery.[[154]](#footnote-155) It was pioneered by Fountain House in the 1940s, and is based on the idea that “community is therapy.”[[155]](#footnote-156) In each clubhouse, an intentional community is created, where members[[156]](#footnote-157) and staff work together to carry out daily operations of the clubhouse, while also providing access to crisis intervention services and connections to resources such as employment, relationship building, education, housing, and daily meals.[[157]](#footnote-158) The model is based on “empowerment of people with SMI and facilitating ‘peer-help.’”[[158]](#footnote-159) Research shows that clubhouses can help reduce hospitalization and justice involvement while improving health and wellness.[[159]](#footnote-160) Although there are typically no overnight stays, membership in clubhouses is voluntary and has no time limits – even when “recovery is achieved,” members may remain active in the community for however long they choose.[[160]](#footnote-161) In New York City, Fountain House is the most well-known clubhouse in operation, with locations in Manhattan and the Bronx, however, there are several others located across the 5 boroughs, including: Brooklyn Clubhouse, Greater Heights Clubhouse (Brooklyn), Open Door Club (Brooklyn), Citiview Connections Clubhouse (Queens), Lifelinks Clubhouse (Queens), Lantern House (Bronx), Chelton Loft (Harlem), Rainbow Club (Manhattan), TOP Clubhouse (Manhattan), and Venture House (Queens and Staten Island).[[161]](#footnote-162)

**How do calls to 988 get routed?**

**Why are 988 investments being built on the foundation of the Lifeline?**

**Why are some of the response rates so low across different crisis call centers in the Lifeline network?**

**What type of training do Lifeline crisis counselors receive?**

**Will my call to the Lifeline be recorded?**

**Are all mental health/suicide prevention crisis centers part of the Lifeline network?Is there a concern that with the transition to 988 and the expected increase in call volume, there will be additional strains put on state and local call centers that are already stretched thin?**

**Why didn’t we extend out the start date of 988 to hash out problematic aressssfsvd**

1. **CONCLUSION**

At today’s hearing, the Committee looks forward to hearing feedback from the Administration, providers, community-based organizations, and advocates on the Mental Health Roadmap Legislative Package, and other concerns related to the mental health crisis occurring nationally and in New York City.

Int. No. 1006

By Council Members Bottcher, Lee, Powers, Riley, Rivera, Louis, Farías, Restler and Hanif

..Title

A Local Law to amend the administrative code of the city of New York, in relation to providing outreach and education regarding mental health services available through NYC Care and through the New York city health and hospitals corporation

..Body

Be it enacted by the Council as follows:

Section 1. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding a new section 17-199.20 to read as follows:

§ 17-199.20 Mental health services outreach and education. a. Definition. For the purposes of this chapter, the term “NYC Care” means the health care access program initially established by the New York city health and hospitals corporation in August 2019 that guarantees low-cost and no-cost services to New Yorkers who do not qualify for or cannot afford health insurance based on federal guidelines, or any other successor program.

b. Outreach and education. 1. The department, in consultation with the New York city health and hospitals corporation, the mayor’s office of community mental health, and other relevant agencies, shall establish and implement an outreach and education campaign to raise public awareness about the mental health services available to members of NYC Care and through the New York city health and hospital corporation. As part of such campaign, the department shall develop and distribute materials in both electronic and print format detailing such mental health services and how such services may be accessed.

2. The outreach and education campaign required by paragraph 1 of this subdivision shall be conducted via the internet, television, radio, and print media.

3. The materials for the outreach and education campaign required by paragraph 1 of this subdivision shall be made available in English and the designated citywide languages as defined in section 23-1101.

§ 2. This local law takes effect immediately

EH

LS #11721

3/24/23

Int. No. 1018

By Council Members Lee, Powers, Rivera, Bottcher, Richardson Jordan, Louis, Menin and Restler

..Title

A Local Law to amend the administrative code of the city of New York, in relation to reporting on involuntary removals

..Body

Be it enacted by the Council as follows:

Section 1. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding a new section 17-199.21 to read as follows:

§ 17-199.21 Report on involuntary removals. a. Definitions. For purposes of this section, the term “involuntary removal” means any removal of a person pursuant to subdivision (a) of section 9.41 of the mental hygiene law or subdivision (a) of section 9.58 of the mental hygiene law.

b. On or before January 1, 2025, and annually thereafter, the department, in coordination with the police department, the fire department, the mayor’s office of community mental health, and other relevant agencies, shall provide to the council and post on its website a report regarding involuntary removals conducted during the preceding calendar year. The report must include, but need not be limited to:

1. The number of involuntary removals conducted pursuant to subdivision (a) of section 9.41 of the mental hygiene law;

2. The number of involuntary removals conducted pursuant to subdivision (a) of section 9.58 of the mental hygiene law;

3. The number of 911 calls that resulted in the involuntary removal or transportation of an individual;

4. Information regarding the locations in which such involuntary removals occurred, including whether an individual was removed from a private dwelling or a public space, such as a park or the public transportation system, or temporary emergency housing;

5. Demographic information of removed individuals, including age, race, ethnicity, and whether the individual was an individual experiencing homelessness;

6. Whether an individual subject to an involuntary removal was admitted to a hospital, and if so, the name and address of the hospital; and

7. The average length of a hospital stay for such individuals.

c. No information that is otherwise required to be reported pursuant to this section shall be reported in a manner that would violate any applicable provision of federal, state, or local law relating to the privacy of individual information or that would interfere with law enforcement investigations or otherwise conflict with the interests of law enforcement.

§ 2. This local law takes effect immediately.

APM

LS #11790+12216

4/13/23

Int. No. 1019

By Council Members Lee, Powers, Rivera, Bottcher, Riley, Louis, Menin, Restler and Hanif

..Title

A Local Law to amend the administrative code of the city of New York, in relation to requiring the creation of a database and interactive map of outpatient mental health service providers in New York city

..body

Be it enacted by the Council as follows:

Section 1. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding a new section 17-199.21, to read as follows:

§17-199.21 Database and interactive map of outpatient mental health service providers. No later than October 1, 2023, the department, in consultation with the health and hospitals corporation and the department of information technology and telecommunications, shall develop and maintain a searchable electronic database and interactive map of outpatient mental health service providers in New York city. Such database and map shall be posted on the department’s website and shall allow outpatient mental health service providers to submit requests to the department for inclusion in the database and interactive map. Such database and map shall include, at a minimum, the following information on each mental health service provider:

1. Address, office hours, and contact information;

2. Mental health services provided by such provider;

3. Whether such mental health service provider accepts insurance and the insurances accepted; and

4. Any other information the department deems relevant.

§ 2. This local law takes effect immediately.

SIL

LS #12091

4/17/23 5:00 pm

Int. No. 1021

By Council Members Powers, Lee, Bottcher, Schulman, Rivera, Riley, Louis and Restler (in conjunction with the Manhattan Borough President)

..Title

A Local Law to amend the administrative code of the city of New York, in relation to crisis respite centers

..Body

Be it enacted by the Council as follows:

Section 1. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding a new section 17-199.21 to read as follows:

§ 17-199.21 Crisis respite center. a. Definitions. For purposes of this section, the term “crisis respite center” means a community-based facility that is designed as an alternative to emergency hospitalization for individuals with severe mental illness in times of psychiatric crisis that offers voluntary stays for up to 1 week, and provides access to behavioral health professionals, peer support groups, psychoeducation, self-advocacy education, and self-help training.

b. The department, in consultation with the mayor’s office of community mental health, and other relevant agencies, shall ensure the creation of at least 2 crisis respite centers in each borough. In determining locations for crisis respite centers, the department shall prioritize communities that have a heightened need for crisis respite centers, as determined by the mayor’s office of community mental health.

c. Crisis respite centers must be open to individuals by appointment, walk-in, or through referrals from medical professionals.

§ 2. This local law takes effect immediately

APM

LS #11719+12100+12100

4/13/23

Int. No. 1022

By Council Members Riley, Lee, Powers, Rivera, Louis and Hanif

..Title

A Local Law in relation to a pilot program establishing community centers for individuals with severe mental illness in high-need areas

..Body

Be it enacted by the Council as follows:

Section 1. a. Definitions. For the purposes of this local law, the following terms have the following meanings:

Community center. The term “community center” means a community-based location designed to support the recovery of individuals with severe mental illness that provides wraparound services and opportunities for social connection for such individuals, including group activities and programming, job readiness skills and transitional employment opportunities, educational opportunities, and access to medical and mental health providers, in a non-residential setting.

Department. The term “department” means the department of health and mental hygiene.

b. Pilot program. The department, in consultation with the office of community mental health and any other appropriate agency, shall establish a community center pilot program. Such program shall establish community centers in at least 5 high-need areas of the city of New York, as determined by the department.

c. Implementation. The pilot program required by subdivision b of this section shall commence no later than 180 days after the effective date of this local law. On or before the date such pilot program commences, the department shall conspicuously post on its website a list of the community center locations established by such pilot program.

d. Report. No later than 1 year after the commencement of the pilot program established pursuant to subdivision b of this section, the department shall submit to the speaker of the council a report containing information regarding such pilot program, including the cost of such pilot program, an analysis of the impact and effectiveness of such pilot program, recommendations for expanding or making such pilot program permanent, and any other recommendations regarding such pilot program.

§ 2. This local law takes effect immediately.

EH

LS #11718

4/13/23

Res. No. 583

..Title

Resolution calling on New York State to subsidize the education and licensing costs of CUNY students who commit to working in the public sector in the mental health professions, which historically experience high turnover rates and staffing shortages.

..Body

By Council Members Joseph, Lee, Rivera, Powers, Louis, Restler and Hanif

Whereas, In the United States (U.S.), one in five adults experiences mental illness annually; and

Whereas, Two in five incarcerated adults have a history of mental illness, while seven in 10 youth in the juvenile justice system have a mental health condition; and

Whereas, In New York State (State), over 2.8 million adults have a mental health condition, and over 4.1 million people live in a community with too few mental health professionals; and

Whereas, In the State last year, more than 1,700 died by suicide and over 550,000 adults had suicidal thoughts; and

Whereas, Over 90,000 people in the State are homeless, with one in six living with a serious mental illness; and

Whereas, In the State last year, about 60 percent of 12- to 17-year-olds who were diagnosed with depression did not receive any care; and

Whereas, According to the National Alliance on Mental Illness-New York State (NAMI-NYS), Governor Kathy Hochul’s “$1 billion [2023-2023 budget] proposal represents the most significant commitment to mental health in the state’s history”; and

Whereas, According to NAMI-NYS and an October 2022 study by a behavioral health advocacy group, behavioral health agencies have a “revolving door of staff,” with the number of new hires almost equaling the number of staff who are leaving, which means that providers are unable to sustain the staffing levels required to deliver needed services in many communities; and

Whereas, According to NAMI-NYS, “investing in programs without investing in the workforce is putting the cart before the horse and leaves the success of [new] programs in doubt”; and

Whereas, The National Alliance on Mental Illness-New York City Metro (NAMI-NYC) praised the New York City (NYC) Council for its Response to the Fiscal 2024 Preliminary Budget, in which it recognized the importance of expanding and supporting mental health services for NYC residents, including a commitment “to develop and retain the mental health workforce”; and

Whereas, A larger mental health workforce would be needed to staff the new programs being called for by Governor Hochul, by the City Council, and by Mayor Eric Adams in his “Care, Community, Action: A Mental Health Plan for New York City,” announced in March 2023; and

Whereas, According to “Addressing the Lack of Diversity in the Mental Health Field,” an article by Rebecca Kim published in March 2022 by the National Alliance on Mental Illness (NAMI), the mental health workforce is predominantly white, even though people of color have a disproportionately higher rate of “adverse mental health outcomes and barriers to care”; and

Whereas, According to the Kim article, having a counselor, therapist, nurse, or other mental health professional with a different racial or ethnic identity can create difficulties for the person being treated; and

Whereas, The City University of New York (CUNY) has the right mix of students from all racial and ethnic backgrounds to draw from in developing a mental health workforce that can best serve all NYC communities, including those often underrepresented; and

Whereas, Providing subsidies to CUNY students to enter and persist in the mental health care field could improve the diversity of that workforce in NYC; now, therefore, be it

Resolved, That the Council of the City of New York calls on New York State to subsidize the education and licensing costs of CUNY students who commit to working in the public sector in the mental health professions, which historically experience high turnover rates and staffing shortages.

LS #11705

4/19/23

RHP

Res. No. 584

..Title

Resolution calling on the New York State Legislature to pass, and the Governor to sign, legislation to enter the Interstate Medical Licensure Compact, the Nurse Licensure Compact, and the Psychology Interjurisdictional Compact, to enhance the portability of medical and mental health providers to become licensed in multiple participating states.

..Body

By Council Members Lee, Powers, Rivera, Bottcher, Riley, Louis and Menin

 Whereas, According to the Kaiser Family Foundation, the rapid increased use of telehealth services during the COVID-19 pandemic played a critical role in meeting the needs of mental and physical health care in America; and

 Whereas, Researchers in the U.S. Department of Health and Human Services found that telehealth visits significantly increased for Medicare beneficiaries as a result of waivers being expanded to include in-home visits during the pandemic due to social distancing concerns; and

 Whereas, According to the Journal of the American Medical Association, during the pandemic, all medical disciplines suffered severe shortages of qualified personnel nationwide, and more than one in five healthcare workers considered reducing their hours or quitting the workforce entirely due to being overwhelmed by stress and the inability to maintain a work-life balance; and

 Whereas, Staffing shortages continue to threaten the medical workforce in New York City, as evidenced by the nurses strike at Mount Sinai Hospital in Manhattan and Montifiore Medical Center in the Bronx, which began on January 4, 2023, and ended January 12, 2023, after both hospitals agreed to add nurses and improve working conditions; and

 Whereas, A federal omnibus bill passed in December 2022 included critical funding to allow Staten Island University Hospital to retain 300 residency slots among “a national physician shortage” complicated by the triple-demic of COVID-19, influenza, and respiratory syncytial virus (RSV), which overwhelmed hospitals in late 2022; and

 Whereas, The Association of American Medical Colleges projects an estimated loss of 124,000 physicians in both primary and specialty care by the year 2034, signaling the need to implement innovative ways of providing care, including telehealth visits, to ensure necessary service delivery; and

 Whereas, While federal standards govern medical training and the U.S. Medical Licensing Examination, each state has its own licensing board and, with limited exceptions for emergency consultations, all physicians must be licensed by the state in which they choose to practice, which serves as a barrier to providing telemedicine in more than one state; and

Whereas, The Interstate Medical Licensure Compact (IMLC) is an agreement allowing physicians to become licensed in multiple participating states, thereby expanding the portability of their medical licensure in order to provide increased medical services; and

Whereas, The Nurse Licensure Compact (NLC) is a multistate license issued by a nurse’s Primary State of Residence that allows a nurse to practice in other NLC states and territories without obtaining additional licenses and, similar to a driver’s license, is recognized across state lines; and

Whereas, The Psychology Interjurisdictional Compact (PSYPACT) is an interstate agreement designed to allow licensed psychologists to practice tele-psychology and conduct temporary in-person practices across state boundaries as a means to provide services to a wider patient population; and

Whereas, New York State Senate bill S.2216, introduced by State Senator Thomas F. O’Mara, and its companion bill A.4860, introduced by New York State Assembly Member Philip A. Palmesano, would enact the IMLC to simplify the processes of allowing physicians to become licensed in multiple participating states and enhance the portability of medical licenses; and

Whereas, New York State Assembly bill A.3391, introduced by Assembly Member Daniel J. O’Donnell, would enact the IMLC and the NLC to strengthen access to healthcare by providing a streamlined process to become a licensed healthcare provider in multiples states; and

Whereas, New York State Assembly bill A.4528, introduced by Assembly Member Brian D. Miller, would enact the PSYPACT, the recognition of emergency medical services personnel licensure interstate compact, and the counseling compact model legislation, which would serve to expand the mobility of the psychology and counseling workforce; and

Whereas, Telehealth services proved invaluable to New York City residents during the pandemic, and digital medical appointments continue to serve as a safe, convenient, and innovative way to access medical and behavioral healthcare for individuals who are unable or prefer not to attend in-person healthcare visits; and

Whereas, The need for medical health professionals to have greater portability and flexibility to practice in more than one state is projected to increase in the future; now, therefore, be it

Resolved, That the Council of the City of New York calls on the New York State Legislature to pass, and the Governor to sign, legislation to enter the Interstate Medical Licensure Compact, the Nurse Licensure Compact, and the Psychology Interjurisdictional Compact, to enhance the portability of medical and mental health providers to become licensed in multiple participating states.

LS #11724

03/29/23

CD

Res. No. 587

..Title

Resolution calling on the New York State Office of Mental Health to expand enforcement of mental health and substance use disorder insurance parity and apply for federal grants to enforce insurance parity.

..Body

By Council Members Powers, Lee, Bottcher, Schulman, Rivera, Riley and Louis

Whereas, According to the Mayor’s Office of Community Mental Health (OCMH), approximately one in five adults in New York City lives with a mental illness; and

Whereas, According to the Substance Abuse and Mental Health Services Administration, less than half of Americans struggling with mental illness receive the treatment they need; and

Whereas, OCMH reports that New Yorkers’ connection to mental healthcare differs significantly by race, ethnicity, sex, insurance status, and neighborhood poverty level, among other factors; and

Whereas, Timothy’s Law of 2006 requires insurance companies in New York State to cover a range of “biologically based mental illness or serious emotional disturbance disorders,” particularly those related to children; and

Whereas, The federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) mandates that health plans provide a level of benefits for mental health and substance use disorder treatments comparable to benefits for medical and surgical care; and

Whereas, The New York State government health and mental hygiene budget for the 2019-2020 fiscal year codified New York State insurance parity requirements consistent with MHPAEA; and

Whereas, According to MHPAEA compliance reports, enforcement efforts have historically focused on minimizing the likelihood of future violations through outreach, compliance assistance, and interpretive guidance; and

Whereas, The 2022 MHPAEA compliance report states that many health plans are still not complying with MHPAEA requirements and that inequities in reimbursement and utilization review for behavioral health services continue to negatively impact access to care; and

Whereas, The persistence of MHPAEA violations makes it clear that compliance assistance alone is not sufficient and a greater emphasis on proactive enforcement is required; and

Whereas, H.R. 2617, the Consolidated Appropriations Act of 2023, includes $50 million of funding spread across five years to help states enforce the federal parity provisions; and

Whereas, To access such parity enforcement funds, states will be required to apply for grants from the Department of Health and Human Services; now, therefore, be it

Resolved, That the Council of the City of New York calls on the New York State Office of Mental Health to expand enforcement of mental health and substance use disorder insurance parity and apply for federal grants to enforce insurance parity.

NM

LS # 11691/LS # 11708

3/21/2023

Res. No. 588

..Title

Resolution calling on New York State to reinitiate the NY/NY supportive housing program, to have both City and State coordinate on supportive housing development and contracting.

..Body

By Council Members Powers, Lee, Bottcher, Schulman, Rivera, Louis and Restler

Whereas, New York City (“NYC” or “the City”) is experiencing a housing crisis in both supply and affordability, with the 2021 NYC Housing Vacancy Survey data finding citywide net rental vacancy rate of 4.54% in 2021, which translates to just 103,200 vacant units out of nearly 2.3 million rental units in the City; and

Whereas, A March 2023 article from TheRealDeal, a real estate news publication, cited U.S. Census data to reveal that NYC’s population rose 4.25% over the past decade, while the number of housing units increased at just 2% over the same time period, and NYC trade association Real Estate Board of New York (“REBNY”) reported that while at least 560,000 new housing units are needed by 2030 to meet demand, the rate of new construction is lagging far behind; and

Whereas, New York City experienced record high rent prices in 2022, with finance analysis group Moody’s Analytics releasing a January 2023 report which, using the Department of Housing and Urban Development’s “rent-burdened” definition of families who direct 30% or more of their income to housing, revealed New York City to be the most rent-burdened metro area in the United States, finding that median-income NYC households would need to pay 68.5% of their earnings to rent an average-priced apartment in the fourth quarter of 2022, far higher than the next highest rate of 41.6% for median-income households in the Miami metro area; and

Whereas, The nonprofit organization Coalition for the Homeless reported that rates of homelessness in NYC reached record high levels in October 2022, citing that the average number of people sleeping in a shelter every night hit 66,000, with that number rising to 72,562 people in January 2023 who spent every night in a shelter; and

Whereas, According to the NYC Human Resources Administration’s (“HRA’s”) Department of Social Services, supportive housing is “affordable housing with supportive social services in place for individuals and families who are homeless or at risk of homelessness”, and the NYC Department of Housing Preservation and Development (“HPD”) describes supportive housing as “permanent, affordable housing with on-site support services to serve the needs of the most vulnerable New Yorkers, including homeless individuals and people with disabilities”; and

Whereas, The NY/NY I, II, and III Supportive Housing Agreements were supportive housing programs that spanned the years of 1990-1993, 1999-2004, and 2005-2016, respectively, and cumulatively resulted in the creation of around 14,000 supportive housing units for those meeting certain criteria, such as homeless persons with mental illness; and

Whereas, The NY/NY Supportive Housing Agreements utilized a legally binding mutual agreement between New York City and New York State (“NYS” or “the State”) that made the City and State partner entities in their commitment to build out supportive housing units, but despite meeting the goals for building out thousands of supportive housing units, the last iteration of the NY/NY Supportive Housing Agreements, NY/NY III, expired in 2016 with no ready replacement agreement between the City and State; and

Whereas, The NY/NY Supportive Housing Agreements have been subject to numerous studies that found numerous benefits arising from the program, including a 2014 report from the NYC Department of Health and Mental Hygiene (“DOHMH”), HRA, and the NYS Office of Mental Health (“OMH”) that found NY/NY III to have saved NYS taxpayers $10,100 per tenant per year, along with improving health, employment, and educational outcomes for tenants, while reports on NY/NY I and NY/NY II similarly found both significant cost savings and improved health outcomes for program participants, with a 2002 University of Pennsylvania study finding that homeless persons placed in the NY/NY program saw reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated; and

Whereas, Given the ongoing homelessness and housing affordability crisis in NYC, having another mutual agreement program with City and State partnership would allow for long-term supportive housing development solutions; and

Whereas, Reinitiating the NY/NY Supportive Housing Agreements would be a crucial step in ameliorating present housing and homelessness crises in New York City by binding City and State agencies to a mutual and legal commitment to develop new supportive housing sites, as former agreements did; now, therefore, be it

Resolved, That the Council of the City of New York calls on New York State to reinitiate the NY/NY supportive housing program, to have both City and State coordinate on supportive housing development and contracting.

CCK

LS #11696

03/29/2023

Res. No. 589

..Title

Resolution calling on the Federal Government to ensure that calls to the 988 Suicide and Crisis Lifeline program are routed based on geolocation rather than area code.

..Body

By Council Members Powers, Lee, Bottcher, Schulman, Rivera, Riley and Louis

Whereas, According to the United States Centers for Disease Control and Prevention (“CDC”), the number of suicides in the U.S. increased 4 percent from 45,979 in 2020 to 47,646 in 2021, after two consecutive years of decline, and a 2022 CNN/Kaiser Family Foundation survey found that nine out of 10 adults believe there is a mental health crisis in the U.S., while both the CDC and the World Health Organization reported seeing a COVID-19 induced spike in mental health emergencies in the U.S. and worldwide; and

Whereas, The 988 Suicide and Crisis Lifeline program (“988 Lifeline”), formerly known as the National Suicide Prevention Lifeline, is the national hotline for those in need of support during a suicidal, substance abuse, and/or mental health crisis or any other kind of emotional distress, and is funded by the federal Substance Abuse and Mental Health Services Administration (“SAMHSA”), administered by the nonprofit Vibrant Emotional Health (“Vibrant”), and managed by state and local entities; and

Whereas, NYC Well, New York City’s suicide prevention hotline, is one of the local entities that operates within the 988 Lifeline network; and

Whereas, The designation of 988 as the national hotline, replacing the former number of 1-800-273-8255, is the result of the National Suicide Hotline Designation Act signed in October 2020, and the Federal Communications Commission required telephone providers to make calling and texting 988 accessible by July 16, 2022; and

Whereas, People can reach the 988 Lifeline by calling or texting 988 or chatting at 988lifeline.org and be connected with a trained crisis counselor, and according to SAMHSA, as of December 1, 2022 there are around 200 local, independently owned and operated crisis centers in the 988 Lifeline network that receive calls, chats, and texts sent to the 988 Lifeline across the nation, with SAMHSA reporting that the 988 Lifeline received roughly 3.6 million contacts in Fiscal Year 2021; and

Whereas, SAMHSA found that most contacts to the 988 Lifeline are calls, with 2.4 million calls making up the 3.6 million contacts received in Fiscal Year 2021, and Vibrant reports that over 80% of calls received are from cell phones; and

Whereas, When receiving a call, the 988 Lifeline’s phone system routes the call to the closest crisis center in the 988 Lifeline network based on the area code of the calling number, not on geolocation technology; and

Whereas, In December of 2020, Vibrant released a report which found that connecting callers to crisis centers is crucial in that doing so connects callers with invaluable resources and support during their mental health crises and thereby mitigates risks and harms stemming from their distress; and

Whereas, The same report included recommendations to process 988 Lifeline calls with geolocation technology because of how many calls come from cell phones, meaning area codes are not a reliable means of accurately locating someone calling the 988 Lifeline, thus routing callers to crisis centers that may not actually be local to them; and

Whereas, The FCC hosted a forum in May 2022 on geolocation for the 988 Lifeline, wherein Vibrant, SAHMSA, experts, and local crisis centers all mentioned the importance of accurately routing a call, stating reasons that included how the inaccurate location of a caller can inhibit the effectiveness of mental health crisis care by delaying access to much-needed care and resources in situations where a caller is not in the same locality as their area code, and that location accuracy is needed to properly judge 988 Lifeline performance metrics and areas of need within states; and

Whereas, The same forum revealed that individuals receive better support from local counselors because local counselors know their area and can quickly connect callers to nearby resources, can reference factors and events familiar to callers to more quickly build trusting connections, and can more easily provide follow-up care and other services that contribute to harm reduction and lessen suicide risk; and

Whereas, Accurately locating a caller is vital to prevent serious harm or death in the cases where callers are at immediate risk of suicide, with Vibrant stating that nearly 1% of callers to the 988 Lifeline are both at imminent risk of suicide and are unable or unwilling to provide their location; and

Whereas, Vibrant found that almost 90% of callers interviewed around 9 days on average after calling the 988 Lifeline stated that the 988 Lifeline helped stop them from killing themselves, and numerous studies of 988 Lifeline calls have shown that most callers were significantly more likely to feel less overwhelmed, depressed, and suicidal after speaking with a 988 Lifeline counselor, including a 2022 study where 89% of those receiving service from NYC Well reported feeling satisfied with their overall experience; and

Whereas, Because the FCC governs whether the 988 Lifeline should or should not use geolocation technology, adjusting federal rules would allow state and local entities to activate and adopt geolocation capabilities and thus allow for more effective crisis care for both current and future callers to the 988 Lifeline; now, therefore, be it

Resolved, That the Council of the City of New York calls on the Federal Government to ensure that calls to the 988 Suicide and Crisis Lifeline program are routed based on geolocation rather than area code.

CCK

LS # 11717

03/29/2023

Res. No. 592

..Title

Resolution calling on the New York State and Federal governments to expand the availability of mental health professionals for low and moderate income New Yorkers by increasing Medicaid reimbursement rates for behavioral health services.

..Body

By Council Members Schulman, Powers, Lee, Rivera, Riley, Louis and Restler

Whereas, According to the Mayor’s Office of Community Mental Health (OCMH), approximately one in five adults in New York City lives with a mental illness; and

Whereas, According to the Substance Abuse and Mental Health Services Administration, less than half of Americans struggling with mental illness receive the treatment they need; and

Whereas, According to OCMH, about 30 percent of the total population of New York City lives in federally designated mental health professional shortage areas; and

Whereas, According to the New York State Office of Mental Health, the demand for mental health care services continues to grow; and

Whereas, Access to treatment for behavioral health conditions relies, in part, on the supply of available providers that accept insurance; and

Whereas, 4,368,608 New York City residents receive their health insurance through Medicaid as of January 2023; and

Whereas, In New York, Medicaid reimburses providers 57 percent of the amount that Medicare does for the same service;

Whereas, Many mental health providers do not accept Medicaid because of low reimbursement rates, according to a 2022 Government Accountability Office report; and

Whereas, Low Medicaid payment rates limit participation in Medicaid and further exacerbate existing shortages of mental health professionals; and

Whereas, According to the Medicaid and CHIP Payment and Access Commission, just 36 percent of psychiatrists accepted new Medicaid patients as of 2019; and

Whereas, New York State’s Medicaid reimbursement rates are set by the Division of Finance and Rate Setting within the Office of Health Insurance Programs under the guidance of the federal Center for Medicaid Services; now, therefore, be it

Resolved, That the Council of the City of New York calls on the New York State and Federal governments to expand the availability of mental health professionals for low and moderate income New Yorkers by increasing Medicaid reimbursement rates for behavioral health services.

NM

LS # 11693

3/23/2023

Res. No. 88

..Title

Resolution calling upon the United States Congress to pass and the President to sign legislation to fully repeal the Institutions for Mental Diseases Exclusion from the Social Security Act to allow states to use federal Medicaid funding to provide mental health and substance use disorder treatment services to adult Medicaid beneficiaries at Institutions for Mental Diseases.

..body

By Council Members Holden, Stevens, Yeger, Bottcher and Powers

Whereas, The Institutions for Mental Diseases (IMD) Exclusion rule has been in place since the beginning of the Medicaid program in 1965 and prohibits the use of federal Medicaid funds to finance services for adults ages 22-64 residing in institutions for severe mental illness, which include hospitals, nursing homes, or other institutions with more than 16 beds that primarily provide diagnosis, treatment, or care for persons living with severe mental illness; and

Whereas, The New York State Office of Mental Health (OMH) operates inpatient mental health care at 24 state psychiatric centers that are classified by the federal government as IMDs—9 of which are known as “Forensic” facilities and serve justice-involved children and adults—and regulates roughly 100 programs operated within general hospitals, also known as “Article 28” facilities; and

Whereas, According to the New York City Mayor’s Office of Community Mental Health, in 2021 there were approximately 280,000 adults living with serious mental illness in New York City; and

Whereas, Nationwide, the public mental healthcare system has shifted from an inpatient to an outpatient treatment model through a process referred to as “deinstitutionalization” to reduce the number of individuals in psychiatric centers; and

Whereas, Under the Cuomo administration, deinstitutionalization efforts were made through the Transformation Plan, which relies on community-based mental health treatment to reduce the average daily census and total number of beds at state psychiatric centers; and

Whereas, Deinstitutionalization has inadvertently placed a heavy financial burden on general hospitals, homeless shelters and NYC jails, all of which have a limited capacity to provide services to individuals living with mental illness; and

Whereas, In New York state, there are more adult psychiatric-care beds located in general hospitals than in state psychiatric centers, which include 4,676 beds in general hospitals compared to only 2,336 beds in state psychiatric centers; and

Whereas, NYC Health and Hospitals (H+H) is the leading provider of inpatient psychiatric care in NYC with 11 H+H facilities that provide 1,219 beds for adult inpatient psychiatric care; and

Whereas, In 2018, there were a total of 28 mental health shelters in NYC and the number of New Yorkers experiencing homelessness and living with serious mental illness has been on the rise according to ThriveNYC; and

Whereas, As of 2018, Rikers Island jail complex is one of the three largest providers of psychiatric care in the United States, with over 40% of the population having a mental health diagnosis and over 10% having a serious mental health diagnosis; and

Whereas, The Centers for Medicare and Medicaid Services (CMS) updated the IMD managed care rules in 2016 to allow federal reimbursement of short stays only of 15 days or fewer in IMDs in Medicaid managed care systems; and

Whereas, In 2018, Congress partially repealed IMD Exclusion by passing the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act or the “SUPPORT for Patients and Communities Act,” which provides federal funding for residential substance-use disorder treatment; and

Whereas, A full repeal that extends to all Medicaid beneficiaries and removes inpatient-day limitations, would allow for better outcomes and provide treatment to adults living with acute and chronic serious mental illness at IMDs; now, therefore, be it

Resolved, That the Council of the City of New York calls upon the United States Congress to pass and the President to sign legislation to fully repeal the Institutions for Mental Diseases Exclusion from the Social Security Act to allow states to use federal Medicaid funding to provide mental health and substance use disorder treatment services to adult Medicaid beneficiaries at Institutions for Mental Diseases.

Session 12

AH

LS 2547

01/27/2022

Session 11

AR

LS #10658

Res. 1001-2019

1. Further discussion of the Mental Health Roadmap is in Section III below. [↑](#footnote-ref-2)
2. Deidre McPhillips, *90% of US Adults say the United States is experiencing a mental health crisis, CNN/KFF poll finds*, CNN (Oct. 5, 2022), <https://www.cnn.com/2022/10/05/health/cnn-kff-mental-health-poll-wellness/index.html>. [↑](#footnote-ref-3)
3. *Mental Health*, World Health Organization, <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>. [↑](#footnote-ref-4)
4. *About Mental Health*, Centers for Disease Control and Prevention (2022). Available at <https://www.cdc.gov/mentalhealth/learn/index.htm>. [↑](#footnote-ref-5)
5. *About Mental Health*, Centers for Disease Control and Prevention (2022). Available at <https://www.cdc.gov/mentalhealth/learn/index.htm>. [↑](#footnote-ref-6)
6. *About Mental Health*, Centers for Disease Control and Prevention (2022). Available at <https://www.cdc.gov/mentalhealth/learn/index.htm>. [↑](#footnote-ref-7)
7. *Id*. The Diagnostic and Statistical Manual of Mental Disorders defines “serious mental illness” (SMI) as a mental health disorder that substantially interferes with or limits one or more major life activities. *Mental Illness*, National Institute of Mental Health (updated Jan. 2022). Available at: <https://www.nimh.nih.gov/health/statistics/mental-illness>. Major life activities include actions such as eating, sleeping, speaking, and breathing; cognitive functions such as thinking and concentrating; sensory functions such as seeing and hearing; and one’s overall ability to communicate and perform the requisite tasks to think, learn, and work. *Introduction to the Americans with Disabilities Act*, U.S. Department of Justice Civil Rights Division. Available at: <https://www.ada.gov/topics/intro-to-ada>. [↑](#footnote-ref-8)
8. Larry McShane et al., *NYC’s mental health crisis spans far and wide with few answers in sight*, Daily News (May 15, 2021), <https://www.nydailynews.com/coronavirus/ny-nyc-mental-health-covid-20210516-zugqg7vmjbctbookukawwccrle-story.html>. [↑](#footnote-ref-9)
9. Press Release, *A Recovery for all of us: Mayor de Blasio announces new programs to support New Yorkers experiencing serious mental illness*, NYC Mayor’s Office of Community Mental Health (April 28, 2021), <https://mentalhealth.cityofnewyork.us/news/announcements/a-recovery-for-all-of-us-mayor-de-blasio-announces-new-programs-to-support-new-yorkers-experiencing-serious-mental-illness>. [↑](#footnote-ref-10)
10. *Serious Mental Illness among New York City Adults*, NYC Department of Health and Mental Hygiene (June 2015). Available at: www1.nyc.gov/assets/doh/downloads/pdf/survey/survey-2015serious-mental-illness.pdf. [↑](#footnote-ref-11)
11. *Id*. [↑](#footnote-ref-12)
12. *Serious Mental Illness among New York City Adults*, NYC Department of Health and Mental Hygiene (June 2015). Available at: www1.nyc.gov/assets/doh/downloads/pdf/survey/survey-2015serious-mental-illness.pdf. [↑](#footnote-ref-13)
13. *Mental Health Data Dashboard*, NYC Mayor’s Office of Community Mental Health. Available at: <https://mentalhealth.cityofnewyork.us/dashboard>. [↑](#footnote-ref-14)
14. NYC Council Press Release, *Speaker Adrienne Adams, Mental Health Committee Chair Linda Lee and Majority Leader Keith Powers Outline Council’s Mental Health Roadmap, Initiating Continuous Legislative and Budgetary Efforts to Solve Crisis* (Apr. 24, 2023), <https://council.nyc.gov/press/2023/04/24/2389>. [↑](#footnote-ref-15)
15. *Id*. [↑](#footnote-ref-16)
16. *Study Reveals Lack of Access as Root Cause for Mental Health Crisis in America*, National Council for Mental Wellbeing (Oct. 2018), <https://www.thenationalcouncil.org/news/lack-of-access-root-cause-mental-health-crisis-in-america>. [↑](#footnote-ref-17)
17. *See, e.g.*, “Biden wants to fix racial inequality. Mental health access is an important place to start,” NBC News, Feb. 17, 2021, available at <https://www.nbcnews.com/think/opinion/biden-wants-fix-racial-inequality-mental-health-access-important-place-ncna1257376>. [↑](#footnote-ref-18)
18. “Mental health desert” is a location where people do not have access to mental healthcare, which may result from issues such as hospital and clinic closures or lack of mental health providers available to treat individuals. Alexis Jones, *What Are ‘Care Deserts’ – And Why Are They a Huge Problem* (Jan. 31, 2023), <https://www.health.com/mind-body/health-diversity-inclusion/care-deserts>. [↑](#footnote-ref-19)
19. *See, e.g.*, “Biden wants to fix racial inequality. Mental health access is an important place to start,” NBC News, Feb. 17, 2021, available at <https://www.nbcnews.com/think/opinion/biden-wants-fix-racial-inequality-mental-health-access-important-place-ncna1257376>. [↑](#footnote-ref-20)
20. *Id*. [↑](#footnote-ref-21)
21. *Id*. Lack of providers will be discussed further in the Mental Health Workforce Shortage section of this Committee Report. [↑](#footnote-ref-22)
22. *Id*. [↑](#footnote-ref-23)
23. *Id*. [↑](#footnote-ref-24)
24. See, e.g., *id*. [↑](#footnote-ref-25)
25. EDP is used in the NYPD patrol guide to refer to a person who appears to be mentally ill or temporarily deranged and is conducting himself in a manner which a police officer reasonably believes is likely to result in serious injury to himself or others. *Patrol Guide*, New York City Police Department (June 1, 2016). Available at: <https://www.nyc.gov/assets/ccrb/downloads/pdf/investigations_pdf/pg221-13-mentally-ill-emotionally-disturbed-persons.pdf> [↑](#footnote-ref-26)
26. Clubhouses are discussed further in the Legislative Analysis section. [↑](#footnote-ref-27)
27. Crisis Respite Centers are discussed further in the Legislative Analysis section. The DOHMH webpage lists 4 Crisis Respite Centers that are “community partners,” but it is unclear if additional centers that are independently run are in operation. [↑](#footnote-ref-28)
28. *Clubhouses*, Mental Health for All, <https://mentalhealthforall.nyc.gov/services/clubhouses> [↑](#footnote-ref-29)
29. *Clubhouses,* Mental Health for All, <https://mentalhealthforall.nyc.gov/services/clubhouses> [↑](#footnote-ref-30)
30. *Crisis Service/Mental Health: Crisis Respite Centers*, *NYC DOHMH*, <https://www.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-respite-centers.page> [↑](#footnote-ref-31)
31. Behavioral health workforce comprises a variety of careers, including psychiatrists, psychiatric nurse practitioners, psychologists, licensed clinical social workers, licensed master social workers, mental health counselors, and more. <https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health> [↑](#footnote-ref-32)
32. *New Study: Behavioral Health Workforce Shortage Will Negatively Impact Society*, National Council for Mental Wellbeing (Apr. 25, 2023), <https://www.thenationalcouncil.org/news/help-wanted>. [↑](#footnote-ref-33)
33. *Id*. [↑](#footnote-ref-34)
34. *Id*. [↑](#footnote-ref-35)
35. *Id*. [↑](#footnote-ref-36)
36. <https://abcotvdata.github.io/mental_health_shortage/providers_by_county.html>. “Mental Health Providers” includes the number of psychologists, psychiatrists, counselors, and other mental health providers. *Id*. [↑](#footnote-ref-37)
37. *USA: New York City Boroughs*, City Population, <http://www.citypopulation.de/en/usa/newyorkcity>. [↑](#footnote-ref-38)
38. *USA: New York City Boroughs*, City Population, <http://www.citypopulation.de/en/usa/newyorkcity>. [↑](#footnote-ref-39)
39. *See, e.g.*, “Biden wants to fix racial inequality. Mental health access is an important place to start,” NBC News, Feb. 17, 2021, available at <https://www.nbcnews.com/think/opinion/biden-wants-fix-racial-inequality-mental-health-access-important-place-ncna1257376>. [↑](#footnote-ref-40)
40. *See, e.g.*, “Biden wants to fix racial inequality. Mental health access is an important place to start,” NBC News, Feb. 17, 2021, available at <https://www.nbcnews.com/think/opinion/biden-wants-fix-racial-inequality-mental-health-access-important-place-ncna1257376>. [↑](#footnote-ref-41)
41. See, e.g., *id*. [↑](#footnote-ref-42)
42. *First Episode Incarceration*, Vera, <https://www.vera.org/publications/first-episode-incarceration-creating-a-recovery-informed-framework-for-integrated-mental-health-and-criminal-justice-responses>. [↑](#footnote-ref-43)
43. Natalie Bonfine et al., *Meeting the Needs of Justice-Involved People With Serious Mental Illness Within Community Behavioral Health Systems*, Psychiatric Services (Dec. 4, 2019), <https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201900453>. [↑](#footnote-ref-44)
44. Megan J. Wolff, *Fact Sheet: Incarceration and Mental Health*, Weill Cornell Medicine (May 30, 2017), <https://psychiatry.weill.cornell.edu/research-institutes/dewitt-wallace-institute-psychiatry/issues-mental-health-policy/fact-sheet-0>. Leah Pope, *Racial Disparities in Mental Health and Criminal Justice*, NAMI (July 24, 2019), <https://www.nami.org/Blogs/NAMI-Blog/July-2019/Racial-Disparities-in-Mental-Health-and-Criminal-Justice>. [↑](#footnote-ref-45)
45. Megan J. Wolff, *Fact Sheet: Incarceration and Mental Health*, Weill Cornell Medicine (May 30, 2017), <https://psychiatry.weill.cornell.edu/research-institutes/dewitt-wallace-institute-psychiatry/issues-mental-health-policy/fact-sheet-0>. [↑](#footnote-ref-46)
46. Leah Pope, *Racial Disparities in Mental Health and Criminal Justice*, NAMI (July 24, 2019), <https://www.nami.org/Blogs/NAMI-Blog/July-2019/Racial-Disparities-in-Mental-Health-and-Criminal-Justice>. [↑](#footnote-ref-47)
47. *Serious Mental Illness (SMI) Prevalence in Jails and Prisons*, Treatment Advocacy Center (Sept. 2015), <https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf>. [↑](#footnote-ref-48)
48. *Id*. [↑](#footnote-ref-49)
49. *Serious Mental Illness (SMI) Prevalence in Jails and Prisons*, Treatment Advocacy Center (Sept. 2015), <https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf>. [↑](#footnote-ref-50)
50. *Serious Mental Illness (SMI) Prevalence in Jails and Prisons*, Treatment Advocacy Center (Sept. 2015), <https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf>. [↑](#footnote-ref-51)
51. Megan J. Wolff, *Fact Sheet: Incarceration and Mental Health*, Weill Cornell Medicine (May 30, 2017), <https://psychiatry.weill.cornell.edu/research-institutes/dewitt-wallace-institute-psychiatry/issues-mental-health-policy/fact-sheet-0>. [↑](#footnote-ref-52)
52. *Mental Health Awareness: The Ultimate Guide [2022]*, Mental Health Foundation, <https://mentalhealthfoundation.org/mental-health-awareness-the-ultimate-guide-2021>. [↑](#footnote-ref-53)
53. *Mental Health Awareness: The Ultimate Guide [2022]*, Mental Health Foundation, <https://mentalhealthfoundation.org/mental-health-awareness-the-ultimate-guide-2021>. [↑](#footnote-ref-54)
54. *Understanding Mental Health as a Public Health Issue*, Tulane University: School of Public Health and Tropical Medicine (Jan. 13, 2021), <https://publichealth.tulane.edu/blog/mental-health-public-health>. [↑](#footnote-ref-55)
55. *Understanding Mental Health as a Public Health Issue*, Tulane University: School of Public Health and Tropical Medicine (Jan. 13, 2021), <https://publichealth.tulane.edu/blog/mental-health-public-health>. [↑](#footnote-ref-56)
56. Mental Health Roadmap, New York City Council, <https://council.nyc.gov/mental-health-road-map>. [↑](#footnote-ref-57)
57. Stephen Eide & Carolyn D. Gorman, *Medicaid’s IMD Exclusion: The Case for Repeal*, Manhattan Institute (Feb. 23, 2021), <https://manhattan.institute/article/medicaids-imd-exclusion-the-case-for-repeal>. [↑](#footnote-ref-58)
58. Stephen Eide & Carolyn D. Gorman, *Medicaid’s IMD Exclusion: The Case for Repeal*, Manhattan Institute (Feb. 23, 2021), <https://manhattan.institute/article/medicaids-imd-exclusion-the-case-for-repeal>. IMD is defined by the Centers for Medicare and Medicaid Services as “a hospital, nursing facility, or other institution with more than 16 beds – or more than 50% of the total beds in the facility – that is devoted to the diagnosis, treatment, and care of individuals with a mental illness.” Kelli South, *New Report Supports Repeal of IMD Exclusion*, Treatment Advocacy Center (Feb. 2021), <https://www.treatmentadvocacycenter.org/about-us/features-and-news/4382-research-weekly-new-report-supports-repeal-of-imd-exclusion>. [↑](#footnote-ref-59)
59. *Id*. [↑](#footnote-ref-60)
60. *Id*. [↑](#footnote-ref-61)
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