NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Ashwin Vasan, MD, PhD
Commissioner

Testimony

of

Ashwin Vasan, MD, PhD
Commissioner
New York City Department of Health and Mental Hygiene

Before the

New York City Council

Committee on Mental Health, Disabilities and Addiction

On

Mental Health Roadmap Legislative Package

May 4, 2023
New York, NY

Good morning, Chair Lee and members of the Committee on Mental Health, Disabilities and Addiction. I am Dr. Ashwin Vasan, Commissioner of the New York City Department of Health and Mental Hygiene. I am joined today by Deepa Avula, Executive Deputy Commissioner for Mental Hygiene and Jamie Neckles, Assistant Commissioner for Mental Health at the Health Department and Laquisha Grant, Acting Deputy Director of Mental Health Systems and Initiatives from the Mayor's Office of Community Mental Health.

Mental health has been a major focus of my life's work, and for me, it represents a coming together of my professional skills and experience in public health, epidemiology, and clinical medicine, with my personal journey, as a loved one of family who have suffered from, succumbed to, and even triumphed over mental illness, and the impact of that journey on my own wellbeing.

I joined the Health Department more than a year ago, therefore, with a deep commitment addressing rising mental health needs of those in New York City, something you have heard me refer to as the "second pandemic". And I am proud to help lead the Mayor's commitment to centering mental health in the public health agenda for the city. It is good to be here with all of you today to discuss the Council's Mental Health Roadmap. Our city's mental health and wellbeing is a shared value and commitment.

We know that every New Yorker is healthier when they live in a city that is healthy, but right now our city's health is declining, and mental health is major contributor to that, both directly and indirectly. The crisis is playing out directly in front of us with escalating overdoses. We lost 2,668 New Yorkers to an overdose in 2021, which is the highest number we have ever seen, and are losing a New Yorker every three hours to overdose. Right now, we are on track to surpass this number in 2022.

We know that the mental health crisis also disproportionately affects young people, who have endured a very difficult few years through the COVID-19 pandemic. I know, firsthand, as a parent, what this looks like. Thousands of our youth are coping with loss of a loved one and have experienced social isolation and loneliness, which as you have recently seen, the US Surgeon General has declared a national health crisis. According to the CDC, nearly 1 in 3 teenage girls say they've considered suicide, an increase of 60 percent from a decade ago.

Further, our neighbors who live with serious mental illness are not getting the treatment they need. On average, the time between the first symptoms of serious mental illness and treatment is 11 years, and the result is too many of our neighbors living with a treatable condition on the streets, cycling in and out of hospitals, or worse, our jails and prisons. We cannot accept this.

In March the Mayor and I announced our historic mental health plan, Care, Community, Action: A Mental Health Plan for NYC, which focuses on these three priority areas: improving mental health of our youth, treating people with serious mental illness, and reducing overdose deaths.

This plan is centers on a public health approach, focusing deliberately on the needs of the most vulnerable to build a system that benefits all, and understanding that it will demand unprecedented collaboration between city, state, and federal partners, to address issues like workforce, housing, and payment, which we are already beginning to see. The plan is ambitious and far-reaching and will affect millions of New Yorkers, while also being pragmatic, focused, and clear. It builds on evidence-based approaches, but also combines innovation and iteration, where best practices are not as well-defined.

Some of the key early initiatives we will be building a new front-door to the system for young people, through a digital mental health program for NYC teens to access mental health services more easily and quickly, and that links to site-based care in schools and in the community, as needed, as part of a continuum of services. We are also committed to addressing the potential impacts of social media on children and adolescents and critically looking at online spaces as harmful health exposures, balancing approaches grounded in policy, regulation, and research, with harm reduction and education for young people, caregivers, and other stakeholders.

For our neighbors living with serious mental illness, we are collaborating with the New York State Office of Mental Health to expand mobile treatment capacity to serve 800 more people and make immense efforts to assist the small subset of acutely ill New Yorkers facing street homelessness and SMI. We are also expanding the capacity of our clubhouses—our one-stop facilities for rehabilitation, treatment, and other services—to provide safe, supportive and "sticky" communities for people with SMI that can reduce hospitalizations, homelessness and criminal legal system contact, while expanding employment and educational opportunities and improving health and wellness. During fiscal years 2022 and 2023, NYC clubhouses have enrolled more than 1,000 new members, and this ongoing growth demonstrates a clear demand for these services as a key pillar of our community mental health system for people with SMI.

We also continue to invest in the expansion of 988 and integration with NYC Well, ensuring that New Yorkers have a clear alternative to 911 for their mental health needs that are not emergencies requiring a response in minutes, while positioning NYC as an exemplar in the path-breaking federal 988 initiative which will create a fundamental shift in how we view access to mental health resources.

To reduce overdose deaths, we continue to support Overdose Prevention Centers as a part of expanded Harm Reduction Hubs and are working to expand these services to reach more communities across the city. We are also enhancing our drug checking work, expanding naloxone distribution, bringing our Relay nonfatal overdose response program to additional hospital emergency rooms, and facilitating access to treatment like methadone and buprenorphine.

From a policy perspective, we are working with the state, academic partners, and other stakeholders on an agenda to build the mental health workforce and continue efforts to increase reimbursement for mental health care in line with federal parity laws. We understand that we

cannot continue to build more and more programs on top of a fundamentally under-resourced and under-capacitated system.

And this is just the beginning, the first floor, if you will, of a multi-level, multi-year effort to build the mental health system we've always deserved, but never had, and need now, more than ever. I am happy to expand upon all the initiatives covered by this plan and answer any questions. I am also looking forward to discussing more specifics on new funding at our executive budget hearing on May 15th.

Turning to the legislation being heard today. These bills are still under review by the Law Department.

Introduction 1006 requires the Health Department to establish and implement an outreach and education campaign regarding mental health services that can be accessed under Health + Hospitals' NYC Care program as well as other H+H behavioral health services. We agree that ensuring New Yorkers know how to find the help and care they need is vital. We want to make sure that New Yorkers are connected to the services that are right for them whether that be at an H+H site or by another community provider. We look forward to working with Council to identify more opportunities to promote NYC Well/988 and mental health services throughout the city.

Introduction 1018 requires the Health Department, in conjunction with NYPD and other agencies, to provide an annual report to Council about involuntary removals conducted pursuant to Mental Hygiene Law sections 9.41 and 9.58. These statutes authorize the removal of a person to a hospital for medical evaluation in the event of observable mental health impairment where the person is conducting themselves in a manner likely to result in serious harm to self or others, which can include harm from clearly unmet medical or basic needs. The goal behind these removals is to improve access to care, reduce social isolation and connect people to stable housing and community-based care. We support collecting, tracking, and reporting on this data to the public annually and look forward to working with Council to ensure this proposal is aligned with the data we have access to and are collecting through our work, as well as ensuring that any data reported does not compromise patient confidentiality and privacy.

Introduction 1019 requires the Health Department to develop and maintain a searchable electronic database and interactive map of outpatient mental health service providers in NYC. The Health Department already provides access to a provider directory through NYC Well/988. Providers can submit requests to be included in this directory. NYC Well/988 is available 24/7 to New Yorkers, where they can speak with a counselor and be referred to available services and providers. We look forward to discussing these capabilities with you further and addressing any concerns. We also want to make sure that we are not creating duplicative systems or resources that can be confusing to the public, and we recognize that the State plays the primary regulatory and oversight role of mental health providers and facilities.

Introduction 1021 requires the Health Department, in consultation with OCMH and other relevant agencies, to ensure that each borough has at least two crisis respite centers, open to walk-ins and referrals. To date, nine crisis respite centers - or Supportive Stabilization Centers as

they are now called - already operate across all five boroughs, half of which are in contract with the Health Department and the other half with the State Office of Mental Health or OMH. These sites are an OMH-licensed service and we expect more to open soon. In 2022, OMH released an RFP for additional Supportive Stabilization Centers as well as a slightly higher level of respite care called Intensive Crisis Stabilization Centers. Further analysis is needed after the additional sites are opened to assess remaining needs throughout the city. We look forward to discussing with you how crisis respite center locations are determined based on the agency's assessment of need and population size.

And lastly, Introduction 1022 requires the Health Department in consultation with OCMH to create a pilot program that would establish community centers for individuals with serious mental illness in high-need areas of NYC. The City's Serious Mental Illness plan outlines the expansion of clubhouses, and the Health Department will soon be releasing a concept paper outlining the planned approach to expanding clubhouses in NYC and specifying high-need areas that are to be targeted. I am a strong proponent of this model having run Fountain House before joining the Administration last year and having previously driven expansion of the model in NYC and across the nation. I look forward to working with Council and discussing how the plan to expand clubhouses accomplishes the same goals in the proposed legislation.

We look forward to this discussion and to answering any questions you might have. We thank you for your collaboration as we work together to address the mental health of our most vulnerable New Yorkers.

Thank you.

PUBLIC ADVOCATE FOR THE CITY OF NEW YORK

Jumaane D. Williams

STATEMENT OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS TO THE NEW YORK CITY COUNCIL HEALTH COMMITTEE JOINT WITH COMMITTEE ON MENTAL HEALTH, DISABILITIES AND ADDICTION MAY 4, 2023

Good morning,

My name is Jumaane D. Williams, and I am the Public Advocate for the City of New York. Thank you to Chair Linda Lee and the members of the Committee on Mental Health, Disabilities, and Addiction for holding this hearing today.

In a given year, one in five New Yorkers experiences psychiatric illness, and hundreds of thousands of those are not connected to care or support.[1] Those who are not receiving treatment or services for their psychiatric disabilities are more likely to be low-income people of more color. Many cities and states across the country are stretched thin with the number of people requiring behavioral health services, and New York City is no exception—and in addition to this, our city is also experiencing an affordable housing crisis, forcing more and more people into the shelter system and the streets, making people experiencing homelessness and/or symptoms of psychiatric disabilities even more visible.

Instead of investing in community-based mental health supports and services, the administration is attempting to police its way out of this mental health crisis. This includes his controversial directive to NYPD and FDNY to involuntarily take people perceived as being unable to take care of themselves to hospitals, regardless of whether they pose any threat of harm to themselves or others. We know that involuntary hospitalization is, at best, a band-aid and may do more harm than good: there is no evidence that court-ordered involuntary treatment in hospitals is more effective than community-based treatment,[2] and has a broad negative impact on many areas of a person's life, often leading to the loss of access to basic rights and services. Further, involving the police when responding to a person in mental health crisis is extremely dangerous and has had historically deadly results, and authorizing the police to detain people based on their own stereotypes of how people with psychiatric disabilities and people experiencing homelessness look and act is dangerous and wasteful. Int. 1018-2023, introduced by Chair Lee, would require DOHMH, NYPD, and other agencies to annually report information regarding these involuntary removals. The Adams Administration has not been particularly forthcoming with data on the implementation of this removal plan, making this bill and the information it would collect critical, as we know people of more color are disproportionately likely to have a police interaction while experiencing a mental health crisis.

In October of 2019, my office released a report, "Improving New York City's Responses to Individuals in Mental Health Crisis," which was both a condemnation of the city's mental health crisis response and a

[1] https://mentalhealth.cityofnewyork.us/dashboard/
[2] https://www.bazelon.org/wp-content/uploads/2022/12/NYC-statement-final-12-12-22.pdf

guide for restructuring and reforming those systems. This report was informed by conversations with and the work of mental health and justice advocates, and was crafted in response to the number of avoidable deaths at the hands of an inadequate, insufficiently trained crisis response system. The recommendations made in our original 2019 report as well as our updated reissue in November 2022 focus on reducing the number of mental health crises requiring emergency response, non-police responses to non-criminal emergencies, and improving crisis intervention training.

At the end of last month, the City Council released a Mental Health Roadmap for addressing our city's mental health crisis with accompanying action items and legislation. Importantly, this roadmap only includes non-police responses and services, and many of the recommendations and action items overlap with the recommendations my office has made, specifically:

- **Respite Centers.** Respite Care Centers are an alternative to hospitalization for those in crisis and serve as temporary stays in supportive settings that allow individuals to maintain their regular schedules and have guests visit. As of 2022, there are 4 Health Department Community Partners operating respite centers serving adult New Yorkers, a drop from the 8 centers in 2019. The Administration for Children's Services also operates a respite program for youth. Int. 1021-2022, introduced by Majority Leader Powers, expands the number of Crisis Respite Centers throughout the five boroughs by at least two per borough, prioritizing areas with high need and open by appointment, walk-in, or referral.
- **Community-based centers and support.** Our report advocates for the expansion of community-based mental health services and support centers, including drop-in centers for unhoused New Yorkers, which provide a variety of services including food, social work, and referrals to needed programs; mental health urgent care centers, which people experiencing a mental health crisis with a short-term alternative to a hospital; and safe havens, a type of immediate temporary housing for homeless individuals that offer supportive services, including mental health and substance abuse programming. Int. 1022-2023, introduced by Council Member Riley, establishes the city's commitment to expand "clubhouse"-style community centers for individuals with serious mental illness, including ensuring that these centers are located in at least five of the highest-need areas.
- **Increasing supportive housing.** Supportive housing is affordable housing with supportive social services in place Currently, the city is lagging behind in providing supportive housing, with a long and often-delayed application process. The City Council has pledged to advocate for the Adams Administration to reevaluate its production goals in the NYC 15/15 supportive housing plan, as well as call on the state to increase supportive housing production. Res. 0588-2023, introduced by Majority Leader Powers, calls on New York State to reinitiate a NY/NY Supportive Housing program to ensure city and state coordination to increase supportive housing development and contracting. The Council has also pledged to advocate for $12.8 million more in the FY24 budget to meet the funding need for 380 units of Justice Involved Supportive Housing targeted at people who cycle between jail, prison, hospitalization, and shelter the most.
- **Expanding Mobile Crisis Teams.** A Mobile Crisis Team is a group of mental health professionals who can provide care and short-term management for people who are experiencing a severe mental health crisis. As of 2022, there are 19 adult MCTs serving the 5 boroughs. There is a great need for an increased number of MCTs as well as an expanded geographical reach and

operating hours beyond the current service hours of 8AM to 8PM. The Council has committed to advocating for the city's FY24 budget to include adequate funding for the expansion of DOHMH's Intensive Mobile Treatment teams, as well as baseline funding for the Mental Health Continuum, which provides Mobile Crisis Teams for children.

In New York City, schools are the main provider of youth mental health services. In the last two years, my office published two reports, "On Reimagining School Safety," and "Invest in Education 2.0." Both reports called on the city to increase mental health supports and services in schools, including increasing the ratio of guidance counselors and social workers to students and adopting a healing-centered framework. I applaud the City Council's commitment to advocating for adequate funding to expand school-based mental health services and to move towards the ratio of 1 social worker per 250 students.

Lastly, it is abundantly clear that New Yorkers need a number to call for assistance in a non-criminal crisis without the fear that the police will respond. Currently, dialing 988 connects the caller to the National Suicide Prevention Lifeline. In New York City, calls to 988 are answered by NYC Well, which is operated by Vibrant Emotional Health, a nonprofit organization with whom the city has contracted to provide this service. According to a report published last week by Fountain House, an organization that connects people living with serious mental illness to clinical support and housing, some 988 callers must wait several minutes before their call is answered, and, if dispatched, a mobile crisis team may take hours to arrive. If a mobile crisis team connects a person to care, the person may have to wait weeks or months before they can be served.[3] People who call 988 are likely in crisis, needing an immediate response and connection to stabilization services, and a delay in care can have catastrophic outcomes, either as the result of self-harm or police contact. Fountain House makes the following recommendations:

- Scale service capacity within the 988 system so that calls can be answered within seconds, mobile treatment teams can respond within minutes, and people experiencing a crisis can be connected to community-based care within hours.
- Continue to improve trust in the 988 system by working with the Peer Oversight Board to create clear and transparent guidelines for responding to mental health crises that involve a weapon or imminent risk of violence and for using involuntary hospitalization as a last resort.
- Invest in significant public education campaigns to encourage people to reach out to 988—not 911—for help during mental health crises.

Since 2019, the list of names lost to inadequate mental health infrastructure has only grown. It is our responsibility now to realize the reforms needed and the urgency of action, to prevent more suffering and loss. I look forward to engaging with the City Council, the Adams Administration, and communities across our city in order to re-center and re-imagine mental health responses in our city.

Thank you.

[3] https://www.fountainhouse.org/reports/rebuilding-mental-health-crisis-response-nyc

OFFICE OF THE BROOKLYN BOROUGH PRESIDENT

ANTONIO REYNOSO
Brooklyn Borough President

City Council Committees on Mental Health, Disabilities and Addiction
Mental Health Roadmap Legislative Package
05.04.2023

Good morning Chair Lee and thank you for holding this hearing today. Ensuring the mental health and wellness of our New Yorkers is a priority for my administration. As Brooklyn Borough President, I have witnessed how the mental health of my constituents are affected by the intersectionality of other quality of life factors, including housing, physical health, poverty, and maternal health.

I am pleased to sign on to many of the bills in the Mental Health Roadmap Legislative Package that are being considered today. Of the bills being considered, I'd like to highlight a few:

Int 1006-2023 requires establishing and implementing an education and outreach campaign on mental health services offered under NYC Care. Over 100,00 of our most vulnerable New Yorkers are enrolled in the NYC Care program because they either cannot qualify for health insurance or do not find marketplace healthcare affordable. I encourage Health + Hospitals to extend its contracts with current community-based partners to support this outreach campaign, who have helped make these enrollments possible since program inception. I also urge Health + Hospitals to ensure that there are plans to expand current, linguistically-appropriate mental health provider staffing to ensure that there is capacity to support the projected increased demand resulting from increased outreach.

Int 1018-2023 requires reporting on involuntary removals. The involuntary removal of individuals experiencing acute mental health crises from our streets and transportation systems cannot guarantee effective mental health outcomes. In fact, it is often retraumatizing and driven by bias. We must ensure that we have plans in place to have adequate psychiatric beds and support systems as those who are involuntarily removed as transferred to care. This bill will ensure that we have accurate data reporting to understand this effort's effect on our unhoused populations, and the resources necessary to adequately serve those transitioned into the system. I also recommend that reporting include whether an individual was provided referrals upon discharge to better assess system capacity for adequate follow-up care.

Int 1021-2023 ensures that each borough has at least two crisis respite centers to provide accessible mental health treatment and resources. We support having this safe, community-based alternative to hospitalization for people experiencing emotional crisis, which also helps reduce

overcriminalization of individuals requiring mental support. Currently, New York City has fewer than 70 crisis beds for a population of over 8 million. However, the proposed one-week stay limitation is insufficient to ensure full stabilization of the individual; while we recognize that length of stay might be limited by cost, capacity, and insurance coverage, an effective program must consider individual needs. Programs should also be made accessible to the uninsured population and the unhoused, with peer specialists who can provide proper referrals. I would also like to see programs that are specialized in care for prenatal and postnatal birthing people, who have specialized needs associated with mental health changes during and after pregnancy. Finally, like at our hospitals and shelters, we need measures to ensure accountability and transparency for the care being provided at respite centers.

Res 0583-2023 calls on New York State to subsidize education and licensing costs for CUNY students committing to a profession in mental health, while **Res 05484-2023** calls for interstate licensure portability. The State's proposals to diversify and increase the mental health workforce to provide linguistically and culturally competent care is a great start. The Council should also consider ensuring that fellows who benefit from subsidized education opportunities are provided pathways and incentives to return to serve within their own communities in NYC. This will provide us to ensure that local shortages of representative workforces are adequately addressed.

Thank you for the opportunity to speak today, and I look forward to working closely with City Council on the next steps in this mental health bill package.

Testimony

New York City Council Hearing Before the Committee
on Mental Health, Disabilities and Addiction
May 4, 2023

Thank you for the opportunity to submit testimony on behalf of the 5BORO Institute — a think tank dedicated to advancing innovative and implementable solutions to tackle NYC's most challenging problems.

We write to express support for Int 1022-2023, sponsored by Councilmember Kevin Riley, to create a pilot program that would establish community centers or “Clubhouses” for individuals with severe mental illness in high-need areas of New York City.

Background

New York City is experiencing a mental health crisis worsening before our eyes. Several high-profile tragedies involving people experiencing psychiatric distress in public spaces — including Simon Martial pushing a woman in front of a train[1] and the recent death of Jordan Neely at the hands of another straphanger[2] — have led to a new sense of urgency for the City to develop a productive path forward.

These horrific deaths share a common denominator: the individual experiencing severe mental illness interacted multiple times with our city’s mental health system before the incident occurred.[3,4] It is critical we stop the revolving doors of our mental health system and go further to aid people in need. Clubhouses cannot solve this alone, but they provide core features that aid in mental health stabilization and recovery, including job and educational opportunities and a sense of community that can help a person to eventually function successfully on their own and hopefully avoid hospitalization altogether.

We are fully in support of this bill, but also believe more needs to be done to deepen connections between community-based providers and medical providers to create stronger accountability for the care of individuals who cycle in and out of the mental health system. Without adequate referrals and oversight, many people who receive limited emergency treatment during a crisis are forced to return to shelters or the streets where symptoms are further exacerbated.[5] This pilot is an opportunity to formalize Clubhouses as a tool to bridge the gap between desperately needed social services and more traditional medical treatment.

---

[1] https://www.nytimes.com/2022/02/05/nyregion/martial-simon-michelle-go.html
[2] https://www.rawstory.com/daniel-penny/
[3] https://www.nytimes.com/2022/02/05/nyregion/martial-simon-michelle-go.html
[4] https://nypost.com/2023/05/06/nyc-failed-to-address-jordan-neelys-mental-health-issues-victim/
[5] https://www.americanprogress.org/article/lack-housing-mental-health-disabilities-exacerbate-one-another/

Clubhouses: Purpose and intention

Clubhouses are recovery centers for people with serious mental illness that help provide the building blocks to successfully reintegrate into society after mental illness has disrupted their ability to function.[6] Clubhouses emphasize and acknowledge the role that social context plays in serious mental illness — termed the “social determinants of health.” These are defined by the World Health Organization as: “the conditions in which people are born, grow, live, work and age that affect health and the rates of illnesses within populations…”[7] Literature has recognized that a lack of socioeconomic opportunities, inability to afford basic needs like housing, food and transportation, and a sense of isolation contribute to poor health outcomes, especially behavioral outcomes.[8] Clubhouses provide skills training and a sense of belonging to aid in long-term success.

There is an amount of stigma for people living with serious mental illness about their dangerousness to the “general public,” and Clubhouses actively work to combat that. Clubhouses work to disrupt that stigma and present a sense of “people, place, purpose” to the lives of members. In contrast to traditional day program models, Clubhouse participants are called "members" (as opposed to "patients" or "clients"), and restorative activities focus on their strengths and abilities, not their illness. The organizing principle of the Clubhouse model lies in its creation of an intentional peer community where members are invited to cooperate or participate in the decision-making of every Clubhouse operation, supported by Clubhouse professional staff known as social practitioners. Membership in a Clubhouse is open to anyone with a serious mental illness, is voluntary, free, and never expires.[9]

Clubhouses: Resolving the failure of multiple systems

Many people with serious mental health challenges have been failed by a series of intersecting issues and a lack of adequate programming. The unique Clubhouse model can help mitigate some of the consequences.

Erik Blutinger, MD, MSc, FACEP is an emergency physician and public health specialist who oversees a Community Paramedicine program in the greater New York City area and serves as a board member of the 5BORO Institute.

“This particular pilot program really drives at the heart of why many people suffer with mental illness — they have nowhere to go for medical care nor support,” Dr. Blutinger said. “Many have no social support available and cannot easily seek medical care due to a lack of outpatient psychiatrists and challenging social determinants. There's a significant boarding issue in emergency departments, too, with many patients waiting for days. There are very few inpatient psychiatric beds available, so these people are unfortunately being squeezed on both ends despite having complex medical problems that really need assistance across multiple disciplines.”

---

[6] https://clubhouse-intl.org/what-we-do/what-clubhouses-do/
[7] https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
[8] https://omh.ny.gov/omhweb/sdmh-white-paper.pdf
[9] *Information provided by Fountain House staff*

Clubhouses are able to offer necessary support, improve self-sufficiency, help boost socioeconomic circumstances and provide more access to traditional medical treatments. These are crucial benefits that are necessary to improve the behavioral health landscape.

Strengthening social support

Studies have shown the impact that social support has on improving mental health.[10] Social networks can aid in offering needed advice and a sense of empathy and understanding for one's situation, especially when provided amongst peers. Social integration — the participation in social relationships — provides a sense of belonging and can protect against maladaptive behaviors.[11] Community has recently been recognized as a major dimension of recovery,[12] which Clubhouses are able to provide. Individuals are able to socially rehabilitate amongst people with shared experiences.

Improving social determinants

Key social determinants that can compound mental illness are the inability to pay for one's most basic needs and to find meaningful employment and educational opportunities. While the proposed wrap-around services in Councilmember Riley's pilot are not delineated, Clubhouses across the City vary in size and scope of services offered.

Fountain House, established in 1948, was the originator of this model of psychosocial rehabilitation and provides the founding principles of Clubhouses that exist all over the city and U.S.[13] Fountain House offers a variety of services and supports in continuing education, housing, and benefits support, amongst other activities. Some proof points from Fountain House include the following: members avoid re-hospitalizations at higher rates, resulting in cost savings of over 20% to Medicaid (versus highest-risk serious mental illness population), nearly 40% of members come in with a recent history of homelessness and within a year of membership over 95% are stably housed, and 30% of members are employed (versus 15% of the general population with serious mental illness).[14]

Making traditional medical treatment more accessible

There are about 100,000 adults in the city with severe mental illness that is untreated.[15] The reasons were probed by a RAND study with support from the NYC Mayor's Office. Patients described having difficulty finding services, navigating systems to access services and

[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5633215/

[11] https://www.cambridge.org/core/journals/epidemiology-and-psychiatric-sciences/article/abs/social-integration-in-global-mental-health-what-is-it-and-how-can-it-be-measured/57B1E065E67F49D9D93BE3968091B9D6

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4564308/

[13] https://www.fountainhouse.org/news/fountain-house-and-new-yorks-14-other-clubhouses-to-receive-new-funding-from-the-city

[14] *Information provided by Fountain House Staff*

[15] https://www.nytimes.com/2023/03/02/nyregion/eric-adams-mental-illness-plan.html

connecting with a trusted provider.[16] Within a Clubhouse people can find a warm environment through which to seek referrals to clinical medical interventions.[17]

Yet, many people experiencing severe mental health challenges may not be aware of existing services they can access, including Clubhouses that already exist in New York City. This gap is highlighted in the City Council Mental Health Roadmap and the importance of public outreach and education campaigns is the focus of a recent bill introduced by City Councilmember Erik Bottcher (Int 1006-2023). The Clubhouse is an excellent entrypoint for behavioral health services, but only if a person is aware of the Clubhouse.

Complex Medical Treatment

As Dr. Blutinger describes above, people are squeezed on both ends of the mental health system because in addition to the issues in the social context, there are a multitude of problems with traditional psychiatric care in emergency settings. If psychiatric beds are not available then people cannot get access to emergency acute treatment, meaning it is very difficult to then transition them to a place like a Clubhouse. On average, psychiatric patients wait over five hours in New York for treatment at emergency rooms.[18]

When an emergency treatment experience is negative that can deter a person suffering from mental illness from seeking further treatment, which continues a cycle of mental illness.[19] We believe additional efforts are needed to resolve these critical issues with acute medical care as we know emergency treatment is key to helping solve our mental health crisis.

Urgency of addressing the crisis and standing up more Clubhouses

The lack of an appropriate safety net on the front-end and the inadequacy of our medical system in treating psychiatric crises at the back-end has reached a crisis. In fact, polling has found 90% of Americans believe we are in a mental health crisis.[20] The situation demands a call-to-action from the community including medical providers, mental health outreach workers, and other individuals who may fall outside of the “mental health” field, but play a big role in the success of mental health.

In many ways Clubhouses act as a sort of small-scale safety net and allow people to grow their skill sets and social capital. We are not alone in our strong support of them. Bi-partisan polling has demonstrated strong public favor for this model, and over 70% of people in the U.S. believe that this country is spending too little on mental health services and wellness.[21]

---

[16] https://www.rand.org/pubs/research_reports/RRA1597-1.html
[17] https://mentalhealthforall.nyc.gov/services/clubhouses
[18] https://www.lohud.com/story/news/2023/01/23/mental-health-er-visits-how-long-are-wait-times-at-ny-hospitals/69820028007/
[19] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9315815/
[20] https://www.cnn.com/2022/10/05/health/cnn-kff-mental-health-poll-wellness/index.html
[21] https://irp.cdn-website.com/167e816a/files/uploaded/public%20memo.Fountain%20House.f.2023.04.25.pdf

Recommendation: Use Clubhouses to help break down silos

Too many people fall through the cracks in the mental health system. The City needs to reduce siloes so that at the end of an emergency mental health episode, psychiatric treatment providers are able to properly refer individuals to community-based programs to encourage long-term recovery. The City also needs an entity or group of individuals to oversee the high-risk individuals who are undergoing repeated treatment and failing to improve.

An individual may be treated during an acute mental health crisis through a number of programs like the emergency room, a crisis respite center or through Community Paramedicine. In Community Paramedicine, a paramedic is dispatched to the person's home where they receive urgent evaluation and treatment, connecting with a virtual physician by way of telemedicine.[22] According to Dr. Blutinger, the challenge comes when it is time to provide a "warm handoff" for the patient.

> "Once that medic leaves it is hard to provide additional support without fully understanding the patient's local geographical context. Examples include understanding their ability to find a job, friends, and/or educational opportunities."

We need emergency room practitioners to be aware of exactly where to send a patient so that they are not returning to circumstances that may have contributed to their original psychiatric crisis, such as a homeless shelter. This is no small task. At minimum, it requires establishing appropriate assessments, determining who administers these assessments, cataloging the available community-based resource centers and ensuring the right "warm handoff" successfully occurs.

Fountain House, for example, helps members connect to housing and operates some housing units of their own (staff estimates roughly 350-400 units). But not all Clubhouses provide this service, and it can vary from Clubhouse to Clubhouse. If housing is not provided, Clubhouses should have their own network of referrals.

To a certain extent, the City Council's Mental Health Roadmap recognizes the need to break down silos amongst healthcare and social service systems. For example, City Councilmember Linda Lee proposed legislation (Int 1019-2023) to create a comprehensive dataset of outpatient facilities that are behavioral health providers to make it easier for referrals.

However, we need to actualize systems across both public and private hospitals to create whole-person treatment based on the unique needs of the patient. Every patient admitted to the emergency room or for short-term care under psychiatric distress should be able to be sent to a program or institution that addresses the underlying cause of their episode so that they are not cycling in and out of medical care.

Further, we need to establish ways or entities to monitor these individuals to help ensure they are on a continued road to recovery over the long-term. Expanding the Clubhouse model is an ideal way to start because the program bridges the critical intersection between the disease and

[22] https://www.mountsinai.org/care/mount-sinai-at-home/services/paramedicine

the social determinants that drive severe mental illness. Clubhouses can help coordinate the separate entities an individual might have to navigate to access medical support and social services. We truly need a unified system where people such as Simon Martial and Jordan Neely are not receiving piecemeal care and falling through the cracks.

Brooklyn Defenders

Brooklyn Defender Services
177 Livingston St, 7th Fl
Brooklyn, NY 11201

Tel (718) 254-0700
Fax (718) 254-0897
info@bds.org

TESTIMONY OF:

Jackie Gosdigian
Senior Policy Counsel, Policy & Advocacy Team

BROOKLYN DEFENDER SERVICES

Presented before

New York City Council

Committee on Mental Health, Disabilities, and Addiction

Oversight Hearing on the Mental Health Roadmap

May 4, 2023

My name is Jackie Gosdigian and I am Senior Policy Counsel at Brooklyn Defender Services. I have been a public defender for 15 years. I want to thank the Committee on Mental Health, Disabilities and Addiction, and in particular Chair Linda Lee, for holding this important hearing today on the City Council's Mental Health Roadmap.

BDS is a public defense office whose mission is to provide outstanding representation and advocacy free of cost to people facing loss of freedom, family separation and other serious legal harms by the government. We provide multi-disciplinary and client-centered criminal defense, family defense, immigration, civil legal services, social work support and advocacy in nearly 22,000 cases involving Brooklyn residents every year.

BDS' interdisciplinary, wraparound model allows us to provide support to people who may have avoided court involvement if they had access to services sooner. We help the people we represent apply for benefits and supportive housing, connect to mental health and substance use treatment, and locate beds in respite centers and safe havens. BDS is proud of having played an important role in the creation of the Brooklyn Mental Health Court in 2002. The Brooklyn Mental Health Court works with people accused of crimes who have serious and persistent mental illnesses, linking them to long-term treatment as an alternative to incarceration. BDS continues to

collaborate with this court to advocate for its expansion to meet the needs of more people, including people with intellectual disabilities and people who have previous criminal legal system involvement.

Earlier this year, we appeared before this committee to express our grave concern about the mayor's plan to expand the forced hospitalization of people experiencing housing instability and living with mental illness. We urged the council to consider why it takes an arrest, investigation, or court involvement for a New Yorker to access meaningful assistance and humane support. We are grateful to this Council for naming the harm of criminal legal system involvement for people experiencing mental health concerns and presenting a roadmap to mental health care that emphasizes non-coercive and non-carceral pathways to treatment.

Intersection of Mental Health and the Criminal Legal System

It is nearly impossible to divorce conversations about mental health from the criminal legal system. The media and public discourse have conflated the two–creating a false narrative which links mental illness to increased rates of violence.[1] This damaging and unfounded messaging exacerbates social stigma and reduces public support of policies that create alternatives to incarceration.[2] New York relies largely on policing and incarceration to address issues related to mental health and substance use. The rollout of non-police responses to mental health crises across New York City has been slow.[3] Police, rather than medical providers, are most likely to respond to people experiencing a mental health crisis.[4] Instances where the police respond to mental health crises often end in abuse or even death.[5]

I. Reporting on the Mayor's Involuntary Removal Program - In. 1018-2023 (Lee)

Mayor Adam's plan to increase involuntary removals of people deemed a risk to themselves or others relies on a short-term emergency response which will not meet the short- *or* long-term needs of people living with mental illness. Forcibly removing people perceived to be mentally ill from

[1] Heather Stuart, Violence and mental illness: an overview, World Psychiatry, June 2003, Available online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525086/

[2] *Id.*

[3] Greg Smith, Cops Still Handling Most 911 Mental Health Calls Despite Efforts to Keep them Away, The City, July 22, 2021, Available online at https://www.thecity.nyc/2021/7/22/22587983/nypd-cops-still-responding-to-most-911- mental-health-calls

[4] National Alliance on Mental Illness, Jailing people with mental illness, 2019, Available online at https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Jailing-People-with-Mental-Illness.

[5] Eric Umansky, It wasn't the first time the NYPD killed someone in crisis, *Propublica*, December 4, 2020, Available online at https://www.propublica.org/article/it-wasnt-the-first-time-the-nypd-killed-someone-in-crisis-for-kawaski -trawick-it-only-took-112-seconds

the street to the most restrictive setting is not only inhumane, it is also ineffective in facilitating the goal of engaging people in mental health treatment.

Forcible removals by the police entail a risk of danger to the person who is experiencing a mental health crisis and does little to increase public safety long-term. When police respond to calls related to mental health crises, they are frequently not trained nor prepared, which is why these calls commonly result in harmful, if not fatal, outcomes. These interactions with police do not result in obtaining proper care for the person in crisis—but rather, the opposite happens. These interactions routinely result in handcuffs and incarceration. "It's why some U.S. jails hold more people with serious mental health conditions than any treatment facility in the country."[6] These interactions also make people vulnerable to police violence; in 2021, at least 104 people across the country were killed after police responded to someone "behaving erratically or having a mental health crisis." [7]

Even when police are properly trained, the simple presence of an armed police officer can escalate tension and trigger anxiety and distress for those who are living with mental illness or behavioral health conditions. As public defenders, we have seen firsthand how police interactions play out all too often. Our most recent cases confirm that an increase in police encounters with those living with mental illness are not resulting in removal to a hospital or care facility, but are instead resulting in arrest, incarceration, and further decompensation.

BDS supports the spirit of Int. 1018 and we encourage the Council to go further to include broader reporting, including:

- Whether an arrest was made,
- Whether a person was transferred to a hospital and not admitted to the hospital, including the average length of stay in the emergency department or Comprehensive Psychiatric Emergency Services Program (CPEP),
- Whether a person was transferred to a crisis respite center, stabilization center, or support connection center, and the average length of stay.

As the Council works to create, fund, and scale-up programs to meet the needs of people with serious mental illness, it is critical to understand if and how these programs are being used by emergency responders.

II. Expanded Access to Intensive Mobile and Community-Based Treatment

We recognize a need for high quality, trauma informed therapy and psychiatry services for adults with serious mental illness (SMI). Inadequate community-based mental health and substance use treatment funnels people struggling with mental illness into handcuffs, jails, and prisons. For people living with SMI, time in city jails frequently exacerbates preexisting mental illness, as

[6] *Id.*
[7] Nicholas Turner, We Need to Think Beyond Police in Mental health Crises, Vera institute, April 2022, Available at https://www.vera.org/news/we-need-to-think-beyond-police-in-mental-health-crises

behavioral health needs are all too often met with violence and isolation rather than appropriate care. After serving time in jail or prison, people return to their communities frequently lacking adequate healthcare infrastructure and access to affordable and supportive resources. These inadequacies lead too often to tragic results–either irreversible sickness and death or the churning cycle of incarceration, lapses in treatment, homelessness, and rearrest.[8]

The Mental Health Roadmap calls for meaningful investment in community care. To ensure that every New Yorker is able to access the care they need, we ask that the city expand evidenced-based treatments available to people with serious mental illness before they are engaged in the criminal legal system. This includes expanding access to Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) teams, investing in community based mental health treatment programs in low-income communities, and training frontline workers on available mental health care options for New Yorkers with serious mental illness.

BDS also strongly supports the expansion of access to Intensive Mobile Treatment (IMT) teams and programs using the community first model. The city must ensure that these programs are sufficiently staffed and that providers receive appropriate compensation. IMT teams and peer based support systems have been imperative, on the ground support for the people we serve. Providers must earn a living wage and the city must work to retain seasoned providers.

III. Expand Access to Affordable and Supportive Housing

As public defenders, we have seen how critical permanent, affordable housing is for the people we serve who are living with SMI. With a safe and stable home, people can engage in treatment more effectively. When their basic needs are met, people can choose to access medication, healthcare, counseling, and services. People with serious mental health concerns are disproportionately homeless or housing insecure, which creates additional barriers for them to access the treatment they need. People experiencing homelessness may have difficulties connecting to providers, affording treatment or medication, or accessing transportation to appointments. We urge the Council to work with the mayor to ensure funding for supportive housing, Justice Involved Supportive Housing (JISH), scattered site housing, crisis respite, and affordable, permanent housing are included in the FY24 budget.

One critical program, the MOCJ Emergency Reentry Housing Program—which has been a lifeline to people leaving the city jails—is scheduled to close at the end of the fiscal year. In April 2020, the City of New York partnered with direct service providers to establish the emergency reentry

[8] The National Commission on Correctional Healthcare has recognized these dangers. See Nat'l Comm. On Corr. Healthcare, About Us, https://www.ncchc.org/about (recognizing that improving the quality of care in jails and prisons not only "improve[s] the health of their inmates," but also "the communities to which they return").

housing program to provide immediate, low barrier to people transitioning out of incarceration. With co-located wrap-around services including medical care, case management, and housing and vocational support, people returning to the community had a safe, stable place to stay and receive care. The current emergency hotel program is scheduled to close on June 30, 2023, with the 530 current residents being moved into transitional housing. This plan, however, fails to serve the goal of using transitional housing to decarcerate Rikers Island. As of February 2023, there were over 375 people on a waitlist for a bed in the emergency hotel program–many of whom are incarcerated only because they do not have stable housing. The Council has a moral imperative to continue to fund this critical program as a step in a continuum of reentry housing.

IV. Crisis Respite

Many of the people we serve would likely not have become court involved if they had safe housing, access to medications, and the support of mental health professionals while addressing a short-term crisis or mediating a concern with a family member or caretaker. While crisis respite centers are available, restrictive policies often prevent people who are court involved, suicidal, or deemed to be acting erratically from accessing beds.

When NYPD responds to a mental health emergency the person in crisis is handcuffed and transported to a hospital for evaluation or a police precinct. Mental health teams, on the other hand, have begun to move away from this practice by providing care in the community, outpatient referrals, and bringing people to crisis respite centers.[9]

The city should continue to fund these critical centers to ensure they are ready to meet the needs of people who choose to access care in crisis, are ready to engage in treatment and need help to stabilize, as well as individuals who are transported by a mental health response team or NYPD. We believe these spaces should be accessible in areas with the highest rates of emergency mental health calls and operated by trusted, community-based organizations, so people in crisis can remain in their own neighborhoods near their support systems while receiving care.

V. Non-Police Response to Mental Health Crisis

For years, BDS has called for the removal of NYPD from all mental health responses, including mental health emergencies, and the expansion of mobile crisis teams. The city has attempted to change the response to serious mental illness (SMI) through piecemeal legislation and pilot programs. As we feared, in the neighborhoods where mental health teams are being piloted, NYPD

[9] B-Heard, Transforming NYC's Response to Mental health Crisis, *Mayor's Office of Community Mental Health,* July 2021, Available at https://mentalhealth.cityofnewyork.us/wp-content/uploads/2021/07/B-HEARD-First-Month-Data.pdf

officers are still responding to mental health emergencies in most cases.[10] Now Mayor Adams is encouraging officers to engage further with people they believe are experiencing mental illness. Allowing the NYPD to continue responding to these calls—even with additional training—does not address the real danger that police pose to people experiencing mental health crises. This plan criminalizes mental illness. Police are not mental health experts or medical professionals, and they should not be tasked with filling this role.

BDS echos the Council's call to fully fund mental health crisis response teams to ensure mental health emergency calls are addressed by medical professionals, clinicians, and peers who are trained in de-escalation methods.

VI. Treatment Not Jails - Res. 156-2022

Over the past few years, the New York State Legislature has championed and won historic legislative change in the criminal legal system. BDS fully supports Res. 156-2022 (Rivera), which calls on the legislature to pass and the governor to sign the Treatment Not Jail Act (S2881B - Ramos/A8524A - Forrest).

As previously stated, New York's current treatment court model has many restrictions on who is able to participate in a diversion program, based on their changes, diagnoses, or personal history. The Treatment Not Jail Act (TNJ) will substantially expand access to judicial diversion and create tangible steps toward ending the criminalization of mental health and cognitive impairments in New York. TNJ will create parity in the court system for vulnerable populations who need support and opportunity, and promote public safety by opening avenues of appropriate, individualized treatment where currently the default is incarceration. TNJ will:

- Create equitable access to judicial diversion by making the current judicial diversion law inclusive of people with mental health challenges and neurological, intellectual, and other disabilities.
- Allow New Yorkers to access treatment regardless of where they live. Currently, some counties will not allow people to participate in treatment court unless they are a county resident. TNJ will enable people to engage in treatment court within their county of residence, regardless of where the offense with which they are charged took place.
- Provide due process protection by ensuring that judicial diversion participants are not jailed without due process by requiring there be some substantiation of violations of judicial diversion conditions.

[10] Greg Smith, Cops Still Handling Most 911 Mental Health Calls Despite Efforts to Keep them Away, The City, July 22, 2021, Available online at https://www.thecity.nyc/2021/7/22/22587983/nypd-cops-still-responding-to-most-911-mental-health-calls

- End automatic exclusions based on level of charge. Currently, some people are excluded from participating in judicial diversion because of the section of the Penal Law with which they are charged regardless of their personal circumstances and background. TNJ will expand access to judicial diversion to people accused of any criminal offense. Research shows that diversion programs promote public safety, and that the nature of the charge does not impact treatment outcomes. TNJ will provide judges with the discretion to give people appearing before them individual consideration.
- Increase likelihood of success by embracing a clinical rather than punitive approach. TNJ will allow individuals to participate in treatment court without requiring them to plead guilty to access treatment. Judges will be trained in the best practices for mental health treatment within the judicial system. These practices will be grounded in providing support for participants and guided by treatment providers' individualized recommendations rather than over relying on punitive sanctions. TNJ will promote collaboration between participants and treatment providers, offering participants the best chance of achieving their treatment goals.

The number of people living with or having experienced mental health issues is at an all-time high, and jails and prisons have become the de facto mental health facilities across New York State. Treatment Not Jail seeks to put an end to this untenable condition and to redirect people out of jails and the criminal legal system and into evidence-based treatment programs that can offer the medical care and support they need.

VII. Strengthen Discharge Planning and Community-Based Mental Health Treatment

We recognize a need for high quality, trauma informed therapy and psychiatry services for adults with SMI. Many of the people we represent have tried for years to access mental health treatment, but face barriers to accessing mental health care in their neighborhoods, in their language, or with providers who are culturally competent. If untreated symptoms lead to a crisis situation, people with SMI may be hospitalized but are discharged and met with a lack of appropriate resources in the community. People seeking care remain on waitlists for months or years for ACT teams, supportive housing, psychiatric visits or other care they require. People we represent are routinely discharged from psychiatric hospitalization or CPEP stay with a referral to first-come-first-serve walk in mental health care and a list of congregate shelters. Others are denied services for requiring a "higher level of care" or having a co-occurring substance use disorder. With no information on where to turn next, they are often met with police, are arrested, and incarcerated.

New York City has invested over one billion dollars[11] in mental health education, outreach, and resources–but low-income New Yorkers still struggle to access care. New York State and federal legislation require insurance providers to offer comparable coverage for mental illness as they do for physical illnesses.[12] Yet many low-income people struggle to find high quality providers who accept Medicaid or Marketplace insurances, and are unable to cover copays for private insurance provided through an employer.

Current mental health paradigms rely upon the highest level of care – Assisted Outpatient Treatment (AOT) and Kendra's Law. While many of our clients have thrived with ACT and FACT teams, this level of intervention is not needed for many people living with SMI. To ensure that every New Yorker is able to access the care they need, we ask that the City expand evidenced-based treatments available to people with serious mental illness before they become involved in the criminal legal system. This must include comprehensive discharge planning from inpatient hospitalization or CPEP visits; expanding access to the previously mentioned IMT teams; investing in community based mental health treatment programs in low-income communities; expanding access to Article 31 and Article 32 clinics; and educating frontline workers on available mental health care options for New Yorkers with SMI. Linkages to appropriate care and warm handoffs to outpatient services must be prioritized. Free, voluntary mental health care must be made available in communities with the highest rates of mental health calls to 911 and must be expanded to include longer hours to reduce instances where people are turned away when seeking help.

Conclusion

The Council's proposed Mental Health Roadmap calls for greater investment in community care. To ensure that every New Yorker is able to access the care they need, we ask that this Council to support funding for the expansion of evidenced-based treatments available to people with serious mental illness before they are engaged in the criminal legal system.

BDS is grateful to the Committee on Mental Health, Disabilities, and Addiction for hosting this important hearing on the Mental Health Roadmap. We thank the Council for its continued support of people living with serious mental illness and acknowledge the critical role the Council plays in safeguarding this community and all New Yorkers. Thank you for your time and consideration of my comments. If you have any questions, please feel free to reach out to me at jgosdigian@bds.org.

---

[11] See for example, Amanda Eisenberg, With opaque budget and elusive metrics, $850M ThriveNYC program attempts a reset, *Politico*, 2019, Available at 2https://www.politico.com/states/new-york/city-hall/story/2019/02/27/with-opaque-budget-and-elusive-metrics-850m-thrivenyc-program-attempts-a-reset-873945

[12] https://omh.ny.gov/omhweb/bho/parity.html

New York City Council Committee on Health and Committee on Mental Health, Disabilities, and Addiction
Mental Health Roadmap Hearing

Good afternoon. My name is Nadia Chait, and I'm the Senior Director of Policy & Advocacy at CASES. Thank you to Chair Lee for the opportunity to testify today. CASES is a nationally recognized leader in the development of innovative programs to address the intersection of unmet mental health needs and criminal legal system involvement. We served over 9,000 New Yorkers last year, of whom nearly 90% identified as Black and/or Latino, consistent with disparities in policing and sentencing. Our programs prevent the harm and trauma of incarceration through pretrial services and alternatives to incarceration (ATI); support achievement of education, employment, health and housing goals; promote mental wellbeing through a range of clinical and case management programs; and improve public safety through community-based solutions.

We specialize in serving individuals with serious mental illness and involvement in the criminal legal system. We know that when people receive the care and support they need, they will live healthy lives in their community, participating as parents, employees, friends and leaders. The City Council's Mental Health Roadmap takes important steps to increase access to mental health services. We commend the Council's comprehensive approach that includes both budget and legislation.

Intro 1018, sponsored by Chair Lee, is a critical piece of legislation to provide insight into the use of involuntary removals. We encourage the Council to require additional reporting to cover the housing status of the person upon discharge from the hospital and to require information on the discharge plan, including how many, if any, outpatient providers were contacted. Far too often, outpatient providers are not notified when a client is discharged, do not have a chance to engage in collaborative discharge planning, and lose the opportunity to meet the client at the hospital to ensure a seamless transition back to community care.

We strongly support **Intro 1021**, sponsored by Council Member Powers, to expand access to crisis respite centers throughout the city. The warm, safe support of a crisis respite center is incredibly beneficial to people in crisis, but these services are currently very hard to access as there are not enough crisis respite centers in NYC. Our mental health programs are based in Harlem with expanding programs in the South Bronx. The Manhattan crisis respite center is over 100 blocks from our programs, and the Bronx site is similarly not convenient to our Bronx clients. We encourage the Council to add language to this bill to require that the new crisis respite centers be located in the neighborhoods with the highest rates of psychiatric

hospitalizations.[1] As the Council looks to support the expansion Support and Connection Centers, we recommend requiring that Support and Connection Centers take referrals from a wider range of stakeholders. Currently, we are able to refer clients in our Supervised Release program to the East Harlem Support & Connection Center, however, we cannot refer clients from our mental health programs to this service. This simply does not make sense, and it limits the reach of this important service. For our clients who we can refer, the Support & Connection Centers have been a very beneficial service, and so we do support the growth of the program, provided that referral pathways are opened up.

We support the intention of **Intro 2019**, sponsored by Chair Lee, to make it easier for New Yorkers to find mental health services. However, we would encourage the Council to consider making this database and map a part of NYC Well. CASES and many other providers are already in regular contact with NYC Well to maintain up-to-date information about our services, including office hours and contact information. Maintaining one consistent database makes it more likely that information will be accurate, and reduces burden on providers. Additionally, many mental health services we provide are offered in the home and community. Pinpointing a provider by their physical location may lead some New Yorkers to conclude that care is not accessible to them, when in reality, the provider may very well be able to travel to that individual's home or meet them in the community. We encourage the Council to incorporate a mobile service designation.

Regarding **Intro 1022**, sponsored by Council Member Riley, we support the efforts to expand the clubhouse model. Clubhouses are a wonderful model to provide the services and supports that people with serious mental illness need. We recommend, however, that the legislation use the term "clubhouse," rather than community center, to clarify the specific model the Council wants to expand. Peer support services should be added to this definition, as peer support is a key part of what makes a clubhouse a clubhouse. Additionally, the legislation must center the role of clubhouse members, who actively participate in the leadership of the clubhouse.

Mental Health Workforce

We strongly support the Council's efforts to address the mental health workforce crisis. CASES currently has 100 vacant positions, representing 1 out of every 6 positions across the organization. We simply cannot expand access to mental health care without providing the essential supports to grow our workforce. We are excited by the proposal for the Social Work Fellows program, which would bring more people into the field and lower the financial entry barriers. We encourage the Council to explore specific supports for the non-clinical workforce, particularly for peers, as well. This could include sponsoring peer certifications and trainings, along with working to develop more robust career ladders for peers. I would also like to share our support for **Resolution 0583**, sponsored by Council Member Joseph.

[1] See, for example "Geographic and economic characteristics of psychiatric hospital stays" in Wojas E, Meausoone V, Norman C. Adult Psychiatric Hospitalizations in New York City. Department of Health and Mental Hygiene: Epi Data Brief (71); June 2016, https://www.nyc.gov/assets/doh/downloads/pdf/epi/databrief71.pdf.

While we appreciate the Council's commitment to advocate for an FY24 budget with adequate funding for nonprofits, we were disappointed not to see any mention of a COLA. CASES cannot continue to provide the same level of services when our costs increase year after year but our city funding does not. This has huge impacts on our workforce, who face the dual onslaught of low, stagnant wages and high caseloads as the real value of funding decreases. We need a 6.5% COLA in the FY24 budget. We are heartened by the Council's commitment to advocate for pay parity across the mental health workforce.

We also support **Resolution 0584**, sponsored by Chair Lee, calling for the State to join the Interstate Medical Licensure Compact, the Nurse Licensure Compact, and the Psychology Interjurisdictional Compact. This would allow more providers to practice in New York, alleviating workforce shortages. We also support **Resolution 0592**, sponsored by Council Member Schulman, calling for higher Medicaid reimbursement rates. Medicaid rates do not cover the cost of care, which leaves CASES unable to provide our staff with the compensation they deserve. It hampers our ability to expand services.

Parity

We support **Resolution 0587**, sponsored by Council Member Powers, calling for OMH to expand enforcement of mental health and substance use disorder parity. When coverage is lacking, people cannot access essential services. We operate a program in the Bronx called OnTrack, which provides early intervention to young people experiencing psychosis. This nationally recognized program offers young people a range of services that improve their mental wellbeing and engage them in education and employment, to get their lives "back on track." Currently, we do not get paid for by any commercial insurer for services we provide to these clients. Similar issues exist across mental health programs when it comes to commercial insurance.

Therefore, this legislation should be expanded to include the Department of Financial Services (DFS), which has primarily regulatory authority over commercial plans. Commercial payers typically have far worse parity violations than Medicaid plans, which are regulated by OMH. DFS must take a much stronger role and a more proactive approach in ensuring compliance with state and federal parity regulations.

Budget Actions

In addition to the items highlighted above, we strongly support the Council's inclusion of the following investment priorities:

- The Council will advocate for the City's FY24 budget to include adequate funding for the expansion of DOHMH's Intensive Mobile Treatment teams, which provide intensive and continuous support and treatment to individuals within their communities where and when they need it. The Council will also advocate for additional investments to expand city-funded Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment teams to provide mobile, intensive case management to people with serious

mental illness, including those with involvement in the justice system, through treatment, rehabilitation, and community integration services.
    - Specifically, the Council should advocate for sufficient IMT funding to eliminate the waitlist for IMT ($1.5 million per team) and for 2 new ACT teams that serve as alternative to incarceration (ATI) teams and 5 new Forensic ACT teams. The State Budget includes 22 new ACT teams for NYC, which the City can leverage to create these new teams at a City cost of $4.625 million ($525,000 per forensic ACT team and $820,000 per ATI ACT team).
- The Council will advocate for the City's FY24 budget to include $12.8 million more to meet the funding need for 380 units of Justice Involved Supportive Housing targeted at the small group of people with the highest level of need, who cycle between jail, prison, hospitalization and shelter the most. These units were committed as part of the Close Rikers points of agreement.
- The Council will advocate for the Administration to reevaluate its production goals in the NYC 15/15 supportive housing plan, towards building two-thirds as congregate units and only one-third as scatter-site units, while continuing to advocate for an additional $45 million to meet the funding need for the plan's remaining supportive housing units.

We also appreciate the Council's commitment to hold a hearing on the B-HEARD plan. It is essential that we have a non-police response to mental health crises. However, the current program is not responding to most calls, has slower response times than police and other emergency services, and has struggled with hiring. We are concerned that the City is expanding the program before it has been successfully piloted. A hearing will allow the Council to assess the current program and what improvements are necessary for expansion.

At a time when too many New Yorkers lack access to the mental healthcare they need, it is truly exciting to see the City Council release such a comprehensive roadmap of how our City can build the mental health system we need. We deeply appreciate the Council's leadership on this issue, and we look forward to working with you to support the roadmap's implementation.

Nadia Chait
Senior Director of Policy & Advocacy
CASES
nchait@cases.org

Testimony of Alice Bufkin
Associate Executive Director of Policy and Advocacy
Citizens' Committee for Children of New York

Submitted to New York City Council Committee on Mental Health, Substance Use, and Addiction
Mental Health Legislative Package and Resolutions

May 4, 2023

Since 1944, CCC has served as an independent, multi-issue child advocacy organization dedicated to ensuring that every New York child is healthy, housed, educated, and safe. CCC does not accept or receive public resources, provide direct services, or represent a sector or workforce. We document the facts, engage, mobilize New Yorkers, and advocate for New York City's children. Our mission is to ensure that every New York child is healthy, housed, educated, and safe.

We would like to thank Chair Lee and all the members of the Committee on Mental Health, Substance Use, and Addiction for holding today's hearing on legislation related to the City Council's Mental Health Roadmap. The Council's focus on mental health is urgently needed, and we look forward to working with the City Council during this budget cycle and beyond.

Confronting the Children's Behavioral Health Crisis

Throughout our city, thousands of families every day face a reality: finding timely mental health supports for children and adolescents is overwhelming, isolating, exhausting, and often impossible.

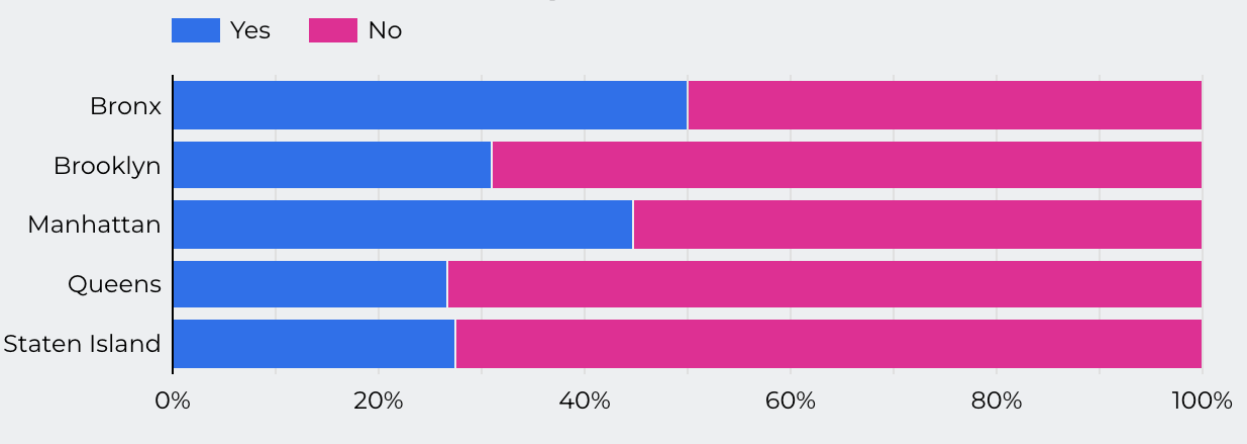
The percentage of children who have anxiety or depression in New York State grew from 8.9% in 2016 to 10.9% in 2020, a 22.5% increase.[i] The American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association have all declared a national state of emergency in child and adolescent mental health.[ii] Alarmingly, providers throughout New York City and the State are seeing waiting lists in the hundreds, leaving families waiting for months for services their children desperately need today.

The foundation for these challenges were laid well before COVID-19 arrived, driven by chronic underinvestment in the children's behavioral health system, deeply inadequate reimbursement rates, and a focus on crisis intervention rather than the full continuum of behavioral supports for children and their families. COVID-19 entered this dramatically under-resourced system to devastating effect, causing widespread loss, economic insecurity, and unprecedented educational disruption.

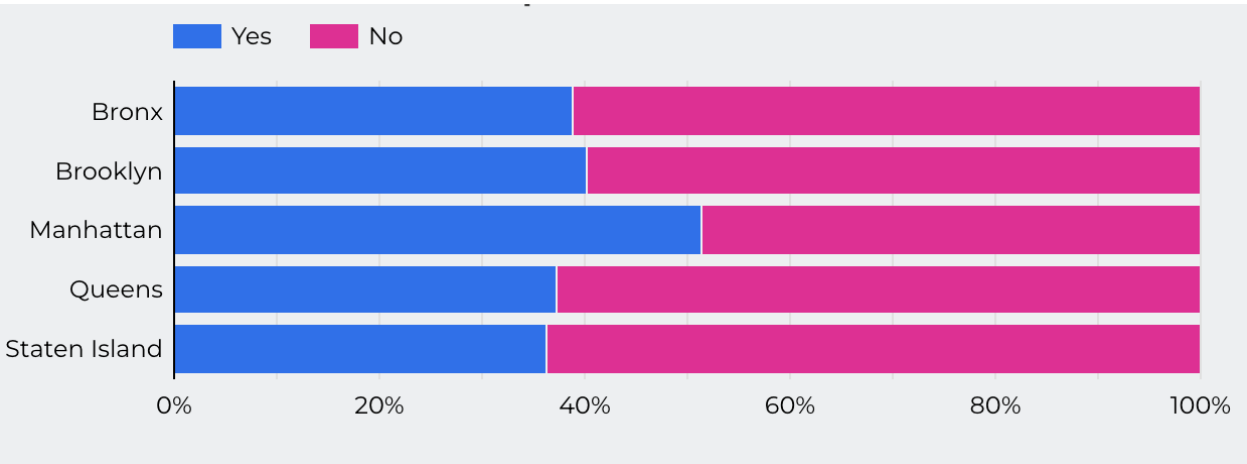
In February 2021, youth advocates and Citizens' Committee for Children launched a survey that collected responses from more than 1,300 young people (ages 14 to 24) across New York City, with a representative share from all five boroughs.[iii] More than a third (35%) of youth report

wanting or needing mental health services from a professional, particularly youth in the Bronx and Manhattan. Among youth who want/need mental health services, only 42% reported receiving these services. Youth identified mental health as one of the greatest challenges and needs in their communities.

Did You Want or Need Mental Health Services from a Professional?



Of Those Who Wanted/Needed Services: Did You Receive Mental Health Services from a Professional?



Source: Voicing Our Future Survey of 1,300+ Youth in NYC, Ages 14-24, February 2021.

Though families in New York have faced significant challenges accessing much-needed behavioral health services, the City has an opportunity to identify and enhance services and interventions that work. With the commitment of our city and state leaders, it is possible to reverse course and transform the children's behavioral health system into one that supports and lifts up families in the face of crisis.

Investing in Mental Health Services in Schools and Communities

We would like to thank the City Council for including a number of critical proposals in its Mental Health Roadmap that we view as essential for addressing the children's behavioral health crisis, several of which are also addressed through legislation and resolutions:

- **Funding and baselining $5 million for the Mental Health Continuum.** As the Council notes in its Roadmap, this is an unprecedented cross-agency partnership designed to enable students with mental health challenges to access direct mental health services in school and connect students to other services throughout the city. This integrated system of targeted and intensive supports includes school partnerships with a number of external partners, including NYC Well, professionals for crisis response, and training for school-staff. Through a partnership between the DOE, H + H, and DOHMH, this model aims to meet the needs of students with significant mental health challenges in 50 schools with the highest rates of NYPD interventions, suspensions, and chronic absenteeism. To fully implement and sustain the Mental Health Continuum, the City must baseline $5 million for the program.

- **Providing $28 million to add new and strengthen existing Article 31 School-Based Mental Health Clinics.** School-based mental health clinics provide on-site clinical services to students, many of which school social workers are barred from providing. These clinics provide essential clinical supports to students, including diagnosis, individual and family counseling, and more. SBMHCs bill Medicaid and insurance directly for services provided to students. However, clinics are not reimbursed for some of the most essential services they provide, including services for uninsured children, services for children without a diagnosis, de-escalating situations where EMS has been called in response to a child's mental health crisis, and trainings and support for school staff and the school population more broadly. The lack of funding outside of the reimbursement structure seriously impairs the ability of clinics to provide more comprehensive, inclusive, and effective services. We are therefore very supportive of the Council's proposal not only to expand the number of school-based mental health clinics, but to provide wraparound funding for existing clinics to ensure their sustainability and enhance their impact.

- **Providing $1.7 million for the Children Under Five program and adding funding for an initiative for mental health services for youth programs run by community-based organizations.** City Council initiatives have for years used non-traditional, community-based settings to help identify children and families in need and offer developmentally appropriate services and support. These trusted community services have been able to adapt to the specific needs of communities and support programs that are challenging to fund through state and federal sources. We therefore strongly support funding for the Children Under Five program, as well as all the City Council's Mental Health Initiatives. We also support the proposal to create a new youth mental health initiative, which could have a more targeted focus on addressing the mental health needs of youth in the city. This new initiative could provide flexible mental health services for youth programs run by CBOs – such as Beacons, Cornerstones, COMPASS/SONYC, and others – with a focus on out-of-school time. Programs would be able to hire mental health professionals, lead structured group activities, or test other innovative, hyper-local solutions to youth mental health needs.

- **Increasing the number of crisis respite centers in the city – and ensuring resources are committed to youth needs.** While we support Council Member Powers' Int. 1021-2023 to

expand the number of crisis respite centers in the city, we strongly urge the city to ensure that half of these are respite programs dedicated to serving youth and families. By supporting young people in crisis, we can prevent the emergence of more complex and acute needs as youth grow into adulthood.

Addressing the Workforce Crisis

CCC is pleased that the Council has dedicated a portion of its Roadmap to addressing the mental health workforce shortage. The workforce shortage is driving children in and out of emergency rooms and onto waitlists for months or years.

We therefore support the Council's proposal to establish a Social Work Fellows Program at one or more CUNY schools, which would subsidize the cost of mental health education, degrees, and licensing, particularly for students who commit to working in public interest mental health professions, which historically experience high turnover rates and staffing shortages. This is also reflected in Council Member Joseph's Res. 0583-2023. In particular, we would like to see supports for those students pursuing a career providing mental health services to children and adolescents.

We must also acknowledge that we will never have an adequate workforce without adequate pay, which is why we are so appreciative that the Council has committed to advocating for **adequate funding for nonprofits and CBOs that currently provide mental health services, as well as pay parity between workers funded by the city and those in the nonprofit sector.** The lack of adequate pay among community based providers is a foundational reason why there are not enough providers in the community, and as a result, why we have so many families waiting for services their children desperately need. **We therefore also strongly support a city-funded 6.5% COLA for the human services workforce.**

Council Member Schulman has filed Res. 0592-2023 to increase Medicaid reimbursement rates for behavioral health services at the state level, and Speaker Adams and Majority Leader Powers have filed Res. 0587-2023 to require the NYS Department of Health to expand enforcement of parity laws and to apply for federal grants to enforce parity. We strongly support enhanced reimbursement rates in Medicaid and are glad that the Council is committed to pushing the state to address deeply inadequate rates. We believe children's rates in particular must be examined for their adequacy, as inadequate rates have for years been a primary contributor to provider shortages and access barriers.

We also believe that a central component of parity is making sure that commercial insurers increase their rates. Commercial insurers continue to operate with impunity, maintaining deeply inadequate rates that result in a deeply inadequate provider network, ultimately contributing to the number of children sent to emergency rooms, hospitals, or worse because their families cannot find or cannot afford providers who take their insurance. Commercial insurers often have huge premiums and copays, forcing families to choose between therapy or paying for basic household needs. Because commercial insurance is so expensive, providers often try to help families qualify for Medicaid. This means that commercial insurance is being subsidized on the

back of Medicaid – the state ends up paying for services that should have been paid for by the plans. We therefore urge city leaders to work with state leaders to enhance enforcement and accountability measures for commercial plans, as well as work to ensure plans pay adequate rates. It is essential that the Department of Financial Services (DFS) be a part of these conversations given their role in determining the state's approach to behavioral health rates, policies, and accountability for parity laws.

Enhancing Outreach and Education Regarding Available Mental Health Supports

We appreciate the focus in the Roadmap on enhancing outreach regarding available behavioral health services.

We support the intent behind Chair Lee's Int. 1019-2023 to create a database on available outpatient services. However, NYC Well currently has an online database that allows users to look up services, including outpatient services. Rather than creating a new database, we recommend identifying ways to improve the existing database. Areas of improvement include providing available information in multiple languages; providing definitions of terminology used to improve accessibility for users; indicating which clinics have clinical capacity to serve children at specific ages; and integrating the services displayed with the services available through schools. H+H and DOHMH should consider working with consumers – both adults and young people – to identify how this database could be more useful.

We also urge city leaders to consider how to support more proactive outreach regarding available services for youth and families, particularly in schools. As a member of the Campaign for Effective Behavioral Supports in Schools (CEBSS), we believe the DOE should make more evident and accessible the mental health services available in each school, the populations they are designed to serve, and the processes for accessing them. This information should be provided in readily-available materials to parents, caregivers, and communities, not only on school websites but also in school choice guides and in methods that do not require digital literacy or internet access. The DOE should also guarantee language access in all materials and media through which resources are shared, and include a list of behavioral health services in school descriptions during middle and high school application processes.

Conclusion

CCC is glad to see a concerted focus by the City Council on improving the mental health of New Yorkers. As the Council continues to consider funding and policy solutions, we urge you to continually consider the specific needs of children and youth and incorporate these needs into policy proposals. We are eager to continue working with the Council to advance a comprehensive strategy to enhance behavioral health supports for children and families across the city.

Thank you for your time and consideration.

[i] Annie E. Casey. *2022 Kids Coutn Data Book: State Trends in Child Well-Being.* August 2022. https://assets.aecf.org/m/resourcedoc/aecf-2022kidscountdatabook-2022.pdf

[ii] American Academy of Pediatrics, "AAP, AACAP, CHA declare national emergency in children's mental health," October 19, 2021. https://publications.aap.org/aapnews/news/17718

[iii] Citizens' Committee for Children, "Voicing Our Future: Surveying Youth on their Priorities for 2021 and Beyond," May 26, 2021. https://cccnewyork.org/voicing-our-future-surveying-youth-on-their-priorities-for-2021-and-beyond/

Committee on Health & Committee on Mental Health, Disabilities and Addiction

New York City Council Mental Health Roadmap Legislative Package

May 4th, 2023

Good morning, Mental Health Chair Linda Lee and members of the Council Mental Health Committee. My name is Cara Berkowitz, and I am the acting director of the Policy Center for the Coalition for Behavioral Health. The Coalition is in the process of merging with the Association of Alcoholism and Substance Abuse Providers (ASAP), making this entity the largest behavioral health care coalition in New York State.

We are deeply grateful for the leadership of Speaker Adrienne Adams, Chair Lee, and the proposals sponsored by Council Members Erik Bottcher, Lynn Schulman, Keith Powers among others. The Mental Health Roadmap Legislative Package comes at a critical time with New York City is facing an unprecedented mental health crisis in communities across all five boroughs.

The statistics for mental health and substance use disorders in our city are both astonishing and heartbreaking: a New Yorker fatally overdoses every 3 hours, and 1 in 5 New Yorkers, over 2 million people, experience a mental health issue each year. Children do not fare much better, with 1 in 6 suffering annually with a mental health concern. While unaddressed behavioral health issues have plagued New Yorkers for years, the COVID-19 pandemic has further exacerbated the problem, highlighting disparities in access to mental health services and resources, particularly in low-income and minority communities. Further compounding this issue is the ongoing opioid epidemic and the deadly infusion of fentanyl and xylazine that is having devastating and oftentimes deadly consequences.

The Coalition for Behavioral Health and ASAP understand that addressing this mental health crisis in our city will require a comprehensive, coordinated effort from all levels of government, as well as collaboration with private sector stakeholders and community-based organizations. We applaud the multi-pronged approach of the Mental Health Roadmap Legislative Package, which aims to pass legislation at the city level and call on state and federal governments for essential additional support. This includes requesting additional Medicaid funding, the development of supportive housing and increased access to mental health services through a well-trained workforce. We are proud of our advocacy for a more robust workforce, including supporting Council Member Erik Bottcher's bill requiring mental health professionals in family shelters. The Mental Health Roadmap Legislative Package addresses this important issue and other critical concerns by focusing on improving access, quality, and coordination of care and we are proud to support its implementation.

The package encompasses a range of proposals that target different aspects of the mental health care system. Some key elements include:

1. Strengthening outreach and education efforts to raise awareness of available mental health services, ensuring that all New Yorkers, regardless of their socioeconomic background, are informed about the resources available to them.

2. Enhancing transparency and accountability in the mental health sector by requiring regular reporting on involuntary removals and the utilization of crisis respite centers, which will help ensure that these facilities are adequately serving their intended purpose.

3. Developing user-friendly tools, such as a database and interactive map of outpatient mental health service providers, to facilitate access to care for individuals and families in need.

4. Expanding the availability of crisis respite centers in each borough, providing a vital alternative to hospitalization for individuals experiencing mental health emergencies.

5. Establishing a pilot program to create community centers for individuals with severe mental illness in high-need areas, offering essential support and resources to some of our city's most vulnerable residents.

6. Advocating for increased Medicaid reimbursement rates for behavioral health services, which will help incentivize providers to offer these essential services to low- and moderate-income New Yorkers.

7. Encouraging New York State to join interstate licensure compacts, which will facilitate the recruitment of mental health professionals from other states, helping to address the workforce shortages in this critical sector.

8. Calling on the state and federal governments to provide additional funding and support for mental health initiatives, including expanding the availability of supportive housing, enforcing insurance

parity, and ensuring that calls to the 988 Suicide and Crisis Lifeline program are routed based on geolocation rather than area code.

We also recognize that the successful implementation of this package will require continued collaboration and communication among all stakeholders involved. As the largest behavioral health care coalition in New York State, the Coalition for Behavioral Health and ASAP stand ready to support the city in its efforts to improve mental health outcomes for all New Yorkers. We are committed to working alongside city officials, mental health providers, and community organizations to ensure that the provisions of this package are effectively put into action.

Moreover, we believe that it is crucial to maintain an ongoing dialogue with the communities most affected by mental health and substance use disorders. By actively engaging with those who have firsthand experience of the challenges faced in accessing care, we can better understand the barriers that exist and identify innovative solutions to address them.

As we move forward, it is essential that we continue to advocate for increased investment in mental health services and support at both the city and state levels. This includes not only direct funding for mental health care providers but also investments in related areas such as housing, education, and workforce development. By taking a holistic approach to addressing the mental health crisis, we can create a more resilient and thriving city for all New Yorkers.

In closing, the Coalition for Behavioral Health and ASAP express our deepest gratitude to the City Council, the Council Mental Health Committee, and all those involved in the development of the Mental Health Roadmap Legislative Package. By working together, we can make a meaningful difference in the lives of countless New Yorkers and build a stronger, healthier city for generations to come.

Thank you for your time, consideration, and dedication to improving the mental health and well-being of all New Yorkers.

Testimony of

The Coalition for Homeless Youth

on

Mental Health Roadmap Legislative Package

Submitted to

The New York City Council's Committee on Mental Health, Disabilities and Addiction

Hearing date: May 4th, 2023

Written Testimony Submitted: May 7th, 2023

Introduction

The Coalition for Homeless Youth (CHY) welcomes the opportunity to submit written testimony focusing on how New York City can better address the mental health needs of runaway and homeless youth to the New York City Council Committee on Mental Health, Disabilities and Addiction. We greatly appreciate the Council's support in highlighting the needs of youth and young adults experiencing homelessness in New York City.

Who are Runaway and Homeless Youth?

RHY are generally defined as unaccompanied young people who have run away or been forced to leave home and now reside in temporary situations, places not otherwise intended for habitation, or emergency shelters. The federal Runaway and Homeless Youth Act defines the population as being between 12-24 years of age. As of April 2017, New York State redefined RHY to be anyone under the age of 25 years[1].

On a single night in 2022, 3,594 unaccompanied and parenting youth under age 25 were counted as experiencing homelessness in the NYC Point in Time (PIT) count.[2] In NYC Fiscal Year 2022, 3,027 RHY, were served in DYCD RHY residential programs, including 329 minors.[3] Another 28,119 RHY received non-residential services at a DYCD RHY drop-in center or through street-outreach[4]. In 2021, DHS reported a total of 4,051 unaccompanied or parenting youth between the ages of 18 and 25 entering either single adult or family shelters,[5] and the Department of Education (DOE) reported that during the 2019-2020 school year, almost 7,500 unaccompanied youth experiencing homelessness attended NYC public schools.[6]

Youth-Specific Shelters and Services Make a Measurable, Positive Difference

The Department of Youth and Community Development (DYCD) has been designated the county youth bureau for NYC and is responsible for serving RHY under the NYRHYA.[7] While many RHY also seek services within the DHS and HRA continuum of shelters, homeless youth, advocates, and RHY providers agree that the outcomes for many homeless youth improve with increased access to youth-specific shelters and services. This was proved in a groundbreaking white paper was released by the Center for Drug Use and HIV Research at NYU Rory Meyers College of Nursing in with the Coalition for Homeless Youth. One of the most significant findings of the study is that high quality RHY programs not only meet basic requirements, but "address higher order relational, psychological, and motivational needs… fostering a sense of resilience among RHY" and providing long-term benefits to a youth's functioning.[8] ***In short, well-funded, high quality RHY programs make a positive impact on a youth's ability to stabilize and successfully transition from crisis to independence***. While more research is needed to evaluate the long-term benefits of RHY services, understanding that these programs make a proven difference to the youth they serve gives further support to why we have continued pushing for more shelter beds and services for youth experiencing homelessness.

Mental Health Needs of Runaway and Homeless Youth

Like all other segments of NYC's homeless population, RHY experience harm that disproportionately impacts their health and creates roadblocks to long-term wellness. This is more recently detailed in "*Opportunity Starts with a Home: New York City's Plan to Prevent and End Youth Homelessness (OSH)*."[9] In the OSH report, it details the myriad of harms that confront RHY, include: increased mental health problems and trauma, substance use, exposure to victimization and criminal activity, and unsafe sex practices. More specifically that almost 50% of youth served at New York State RHY programs reported needing mental health services, and in

[1] https://www.nysenate.gov/legislation/laws/EXC/A19-H
[2] https://files.hudexchange.info/reports/published/CoC_PopSub_CoC_NY-600-2022_NY_2022.pdf
[3] https://www1.nyc.gov/assets/dycd/downloads/pdf/FY22_LL86_RHY_Demographics-and-Services_Report-final.pdf
[4] Ibid
[5] https://www1.nyc.gov/assets/home/downloads/pdf/press-releases/2022/NYC-Community-Plan-DIGITAL.pdf
[6] Ibid
[7] New York State FY 2018-19 budget included amendments to the NYRHYA that expand the age range for RHY services and youth-centered beds to 25 years old. The amendments took effect January 1, 2018. (SFY 2018-19 Budget, Part M S2006-c/30060c; *see* https://www.budget.ny.gov/pubs/press/2017/pressRelease17_enactedPassage.html.
[8] Gwadz, M., Freeman, R., Cleland, C.M., Ritchie, A.S., Leonard, N.R., Hughes, C., Powlovich, J., & Schoenberg, J. (2017). Moving from crisis to independence: The characteristic, quality, and impact of specialized settings for runaway and homeless youth. New York: Center for Drug Use and HIV Research, NYU Rory Meyers College of Nursing. *See page* 16.
[9] Ibid

NYC over 90% of homeless youth have reported experiencing trauma, 92% self-reported having anxiety or depression, 69% reported using drugs and 60% specifically self-reported that they had been diagnosed with having bipolar disorder.[10] Furthermore, homeless youth also experience increased levels of criminalization and discrimination due to their intersecting identities. In NYC, over 90% of homeless youth identify as a race other than white (non-Hispanic) and Youth of color and LGBTQ/TGNC youth are also vastly overrepresented in the RHY population[11].

In addition, homeless young people reported a distinct challenge in accessing services, including finding it hard to receive a stable level of care due to having to go to multiple programs and appointments across the city to address their needs. This highlights the great need for robust healing-centered mental health supports and services throughout the RHY programs, unfortunately funding for these services continues to fall short of meeting the need.

Care, Community, Action: A Mental Health Plan for New York City

The reality is that the mental health needs of unhoused youth and young adults are going unmet by the city's youth homeless system, and we fear that the treatment of unhoused young people struggling with more persistent mental health needs will only get worse under the "*Care, Community, Action: A Mental Health Plan for New York City.*[12]"

Like many nonprofits in other sectors, Runaway and Homeless Youth (RHY) service providers, the majority of whom are funded by the Department of Youth & Community Development (DYCD), echo the concerns raised by many legal services organizations that the City's broad language in the NYC Removal Directive would allow removals that are not justified under the U.S. Constitution or State mental health law. The City's language announcing this initiative both reflects and will exacerbate bias against unhoused young people and young people with serious mental illness, in violation of anti-discrimination principles, and the NYC Removal Directives will disproportionately target people of color. This initiative directs resources into a failed strategy, at a time when the City has reduced investments in effective strategies that connect people to long term treatment and care, and this plan fails to address what the mayor is proposing regarding youth specifically. The City's new directive on "mental health involuntary removals"[13] (the "NYC Removal Directive") purports to clarify that the NYPD and other agencies are empowered to forcibly remove from public spaces people who appear to have a mental illness and to be unable to meet their basic needs, including shelter, food, and medical care, to an extent that causes them harm.

This vague and broad initiative, as outlined in the mayor's announcement and accompanying directive, raises significant legal issues that demand careful review to ensure the City's compliance with City, State, and Federal anti-discrimination laws. Furthermore, as is evidenced by the numerous concerns raised by directly impacted individuals and groups advocating for people with mental illness, the new directive also presents serious policy concerns that deserve thoughtful consideration and would benefit from additional stakeholder input. Below we have highlighted a number of priority mental health needs that remain unmet in regard to RHY.

General Needs

- **Fund mental health focused RHY Transitional Independent Living Programs (TIL)**
  Young people often share that they wish they had better access to meaningful mental health supports. Providers continue to express that they often do not have the staff capacity or appropriate structure to support RHY who have significant mental health needs. The City should fund two new pilot programs to serve RHY with mental and behavioral health needs, mirroring what already exists in the DHS system, these programs would include on-site clinical services, and intensive case management to provide youth with the services they need.

[10] Ibid
[11] Ibid
[12] https://www.nyc.gov/assets/doh/care-community-action-mental-health-plan/index.html
[13] https://www.nyc.gov/assets/home/downloads/pdf/press-releases/2022/Mental-Health-Involuntary-Removals.pdf

- **Alleviate barriers to timely placement in Permanent Supportive Housing**
  RHY providers encounter barriers when referring youth to supportive housing or in-patient clinical services. The city must improve its coordination through the CAPS system to ensure that youth that require long-term and permanent housing that supports their mental health needs is improved.

Plan Specific Needs

- There needs to be clear policies regarding what training responding entities will receive regarding RHY (NYPD, FDNY, EMS).

- There needs to be a coordinated discharge plan between DYCD providers and Hospital's.

- There needs to be a plan regarding how minors will be treated under this plan, specifically those that are involuntarily committed and who could be negatively impacted if communication and discharges from psychiatric services are linked to returning to unsafe home environments that they previously led. This plan must account for youth that will not be served through ACS.[14]

- There needs to be guidance and resources provided for unaccompanied migrant minors and young adults who are experiencing trauma and lack of support around mental health while receiving services from RHY programs.

We look forward to working with council to address the issues outline in our testimony and are available to answer any follow-up questions that you may have.

For questions please contact:
Jamie Powlovich
Coalition for Homeless Youth, jamie@nychy.org, (347) 772-2352

The Coalition for Homeless Youth

Founded in 1978 as the Empire State Coalition of Youth and Family Services, The Coalition for Homeless Youth (CHY) is a consortium of 65 agencies whose mission is, as a membership organization, to use its collective voice to promote the safety, health, and future of runaway, homeless and street involved youth through advocacy, authentic collaboration with youth and young adults (YYA) with lived expertise and training and technical assistance.

CHY is primarily an advocacy organization, leveraging the expertise and experience of its membership as well as YYA with the lived experience of homelessness to shape the landscape for runaway and homeless youth across New York State. This is achieved by increasing public awareness, coalition building, policy work and public advocacy campaigns for pertinent legislation and funding. Notably, in 2015, CHY was instrumental in the advocacy efforts that resulted in the doubling of the State budget for runaway and homeless youth services. CHY's advocacy also contributed to the development of NYS statutory and regulatory changes that became effective in 2018, permitting localities across the State to extend length of stay and increase age of youth served by RHY programs in their communities. Most recently, we passed state legislation this session that will grant decisionally capable runaway and homeless minors the ability to consent to their own health care, including gender-affirming care. As well as NYC legislation that we maintain gives both homeless youth and youth aging out of foster care access to city-sponsored housing vouchers.

An additional area of focus for CHY is the strengthening of service delivery for runaway and homeless youth, primarily through the provision of specialized trainings and technical support. Until 2019, CHY held the state contract to provide annual web-based trainings, on diverse topic areas, to providers across the state, reaching hundreds of professionals working with homeless and runaway youth. Since 2019, CHY has continued to provide training and technical assistance on a smaller scale due to funding restrictions; however, resuming this service remains a top priority for our membership.

Lastly, and most importantly, as a coalition and voice for a community that is often overlooked, underrepresented and under-resourced, CHY prides itself on ensuring that the majority of our staff have the lived experience of youth homelessness. Our commitment to giving power to those with lived experience is also prioritized through our support of the New York City Youth Action Board (YAB), as well as our annual Youth Advocacy Fellowship Program and new Homeless Youth Peer Navigation Pilot. These initiatives not only expand the way that CHY is authentically collaborating with YYA who have the lived experience of homelessness, but it also awards us the ability to work together with YYA, to give them the tools and supports needed so that they can effectively create change.

Testimony before the Joint New York City Council Hearing with the Committee on Mental Health, Disabilities, and Addition
May 4, 2023

Presented by:
Cal Hedigan, Chief Executive Officer
Community Access, Inc.

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

www.communityaccess.org

Good morning. Thank you to Chair Lee, and the rest of the Mental Health committee for convening this important hearing. I appreciate the opportunity to testify on behalf of Community Access.

I am fortunate to serve as the CEO of Community Access, a nearly fifty-year old organization that is one of the most person-centered supportive housing and mental health-related agencies in New York City. Each day, I work alongside a team of more than 350 people who devote time and care towards connecting thousands of people who are living with mental health concerns with the housing, education, and healing focused services they need to move forward with their lives. I've seen firsthand the transformative nature of immediate, community-based resources, and I am here today to voice my support for the aspects of the City Council's Mental Health Roadmap that reflect these values.

The City Council's recently announced Mental Health Roadmap is a welcome development and we appreciate the Council's attention to our city's mental health system needs.[1]

Community Access supports efforts to increase the number of crisis respite centers in the five boroughs. Having operated the City's first ever crisis respite center since 2012, we know that respite centers offer a healing, home-like environment where people can get support in a time of crisis and work with peers to advance their recovery goals. Respite centers are an important part of the fabric of non-hospital alternatives for recovery and healing to take place.

We support the Council's call for establishing a new NY/NY agreement. Further investment in permanent, supportive housing is the only way to address the city's ongoing housing crisis. As one of New York's leading providers of supportive housing, we stand ready to partner with the City and the State to advance New York's vision of a home for every New Yorker. Relatedly, we join the Council in calling on the State to create a flexible preservation fund to allow the modernization and preservation of decades-old units. As we look to develop new housing units, it is critical to adequately resource preservation and review the bricks and mortar operating subsidies necessary for building to be well maintained today and in the future.

Community Access wholeheartedly supports the Council's advocacy to expand Intensive Mobile Treatment (IMT) teams. As an organization that currently operates five IMT teams, we know how effective this particular model is in creating authentic connections with New Yorkers who have been failed by other, traditional models of treatment.

Community Access is proud to belong to the Human Services Council's #JustPay campaign. The human services sector, which employs 80,000 people — predominantly women and workers of color — are some of the lowest paid workers in New York City while also being the lifeblood of the city.[2] It is these individuals who are responsible for many of the programs and services I

[1] https://council.nyc.gov/mental-health-road-map/
[2] https://www.justpayny.org/

speak of today, and yet at Community Access, our staff vacancy rates have been close to 30% for several years due to structural issues with wages in the sector. The high staff vacancies make the work so much harder for those that remain in the workforce, contributing to burn out and low morale, which then leads to more turnover. New York City must take action to change this.

Government contracts either directly set low-salary levels, or do so indirectly by establishing low rates for services along with required staffing levels on a contract. This creates low starting salaries that are often stagnant because human services contracts last five to seven years (or more) with no opportunity for cost-escalators to allow for increasing workers' salaries.

We echo our #JustPay campaign peers in calling for the following:

- Establish, fund, and enforce an automatic annual cost-of-living adjustment (COLA) on all human services contracts.
- Set a living wage floor of no less than $21 an hour for all City and State funded human services workers.
- Create, fund, and incorporate a comprehensive wage and benefit schedule for government contracted human services workers comparable to the salaries made by City and State employees in the same field.

We also wish to voice our support for the Council's efforts to finally hold an oversight hearing on the City's Behavioral Health Emergency Assistance Response Division (B-HEARD) program. According to the very little data the Mayor's Office of Community Health (OCMH) has released, we can see that the program, as it stands, is failing to meet its stated objectives.[3,4,5] NYPD is still responding to the majority of crisis calls in the pilot areas. Given that the City intends to expand the B-HEARD program, we must have greater transparency into the inner-workings of the program. This will aid in understanding the barriers to implementing a true non-police response and creating a plan to address them. We advocate for no further expansion of B-HEARD until an oversight hearing is convened.

Relatedly, we join the Council in its advocacy to compel OCMH to provide data on the Mayor's involuntary removals initiative. We have testified before about our position on involuntary removals and the harms that they cause. We remain opposed to any further investments in programs that compel people into treatment rather than working alongside people to support them to achieve the goals of their choosing. For as long as this directive remains in effect, we insist that OCMH provide transparency on the initiative so that the public can understand what is happening to the individuals subjected to involuntary removals.

---

[3] https://mentalhealth.cityofnewyork.us/wp-content/uploads/2022/10/FINAL-DATA-BRIEF-B-HEARD-FY22-TOTAL.pdf
[4] https://www.thecity.nyc/2022/7/18/23267193/mental-health-911-b-heard-teams
[5] https://www.nydailynews.com/new-york/ny-mental-health-crisis-teams-b-heard-problems-20221114-dv2rnt5g2vfczckthdocvf2boe-story.html

We echo the Council's call to ensure that 988 calls are routed based on geolocation and not based on phone number area code. This change is necessary to ensure that the supports offered to callers are appropriately tailored to their real-time locations.

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

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

Covenant House New York

460 West 41 Street
New York, NY 10036

ny.covenanthouse.org

New York City Council, Committee on Mental Health, Disabilities and Addiction

May 4, 2023

My name is Jayne Bigelsen, and I am the Vice President of Advocacy at Covenant House New York (CHNY), where we serve young people experiencing homelessness and human trafficking ages 16 to 24. I would like to thank the New York City Council Committee on Mental Health, especially Chair Lee, for the opportunity to testify today.

CHNY is the nation's largest, non-profit adolescent care agency serving homeless, runaway and trafficked youth. During this past year, CHNY served over 1,600 young people in our programs. Our youth are primarily people of color and over a third of our young people have spent time in the foster care system. A disproportionately high percentage of our youth struggle with the pervasive impacts of trauma, mental health issues, and substance abuse. We provide young people with food, shelter, clothing, medical and mental health care, and substance abuse services, legal services, high school equivalency classes, and other educational and job-training programs, as well as specialized services for survivors of human trafficking/commercial sexual exploitation. All of these services help young people overcome the trauma of homelessness and abuse and move toward stability, security, and a successful future free from exploitation.

One of the greatest needs and scarcest resource for young people experiencing homelessness and human trafficking is mental health care. We were incredibly grateful to see the Council's courageous mental health roadmap which can pave the way forward in alleviating New York City's decades- in -the making mental health crisis.

Youth Specific Respite Mental Health Beds

CHNY is fortunate to have 14 social workers on staff and a mental health day program, but no organization serving young people experiencing homelessness in New York City can afford a full-time psychiatrist. The waitlist for psychiatric appointments for homeless youth across the city can be long, thereby leading to unnecessary delays in care.

Our mental health staff is adept at dealing with mental health concerns, including anxiety, depression, PTSD, bipolar disorder, among many other disorders. However, in recent years we have seen an increase in young people with schizophrenia, psychosis and active suicidality as well as young people with severe developmental disabilities. Young people with these conditions often need more mental health support than runaway and homeless youth (RHY) programs can provide.

In these cases, we will advocate to hospitalize the young person in order to ensure their safety. However, frequently the hospital will only keep the youth for 24 hours before returning them to our care. The young person is then bounced back and forth between homeless youth service providers and hospitals and does not receive the intensive 24/7 mental health care that is essential for their recovery.

If enacted, NYC Intro 1021-2023 would be an important step forward in reducing the number of youth caught in the never-ending cycle of hospital to shelter and back again. Crisis Respite Centers are exactly what many of our youth need so they can be stable enough to create a long-term plan that will lead to mental wellness and successful futures, while avoiding unnecessary hospitalizations.

We have several recommendations to ensure the success of the respite centers discussed in Intro 1021-2023. First, we ask that some of these centers be dedicated specifically to young adults between the ages of 18-25. Our young people have repeatedly expressed that they do not feel comfortable in residential programs of any length that are not age specific. Our young people will typically choose to forgo mental health care and sleep on the streets over programming that requires cohabitation with older adults who often intimidate them. Additionally, young people have unique developmental needs, and late adolescence and young adulthood are often the time that a variety of mental health symptoms can first appear. Our youth deserve mental health programs that use positive youth development principles and evidence-based models that are specific to young adulthood.

Through our work with young adults, we know that seven days is insufficient to provide true respite and stabilization of most mental health issues. A sense of safety and trust of adult staff is essential for youth to be active participants in the creation of their long-term wellness plan, but

trust and a sense of safety may need more than seven days to build. Often our young people need a week to rest before they can begin to discuss and confront their mental health concerns. A seven-day program would often end services just as a young person starts to feel comfortable opening up and discussing their mental health concerns. Instead, we recommend the piloting of at least two 21–30-day residential mental health treatment programs for young adults between the ages of 18-25. These centers could be modeled after ACS' Rapid Intervention Centers which provide a stabilizing and safe living environment for 21 days where young people can successfully plan for their long-term mental health and housing needs. More about ACS' 21-day respite /mental health treatment centers can be found here, including an example of one used by the Children's Village.

Louis Jackson Rapid Intervention Center (RIC) - The Children's Village (childrensvillage.org)

https://www.nyc.gov/assets/acs/policies/init/2012/H.pdf

Youth Specific Long-Term Mental Health Beds

Additionally, there are no long-term youth mental health beds in New York City, and at times we have had to make referrals out of state. This leaves young people with mental health needs beyond homeless youth providers' capacities languishing in our programs, while being bounced from one program to another. These young people often take an exorbitant amount of staff time and attention away from other young people.

When leaving a hospital or respite center, young people with significant mental health needs require long-term treatment to continue their progress toward wellness. Without long-term youth mental health beds, any progress they have made in a respite center or youth homeless shelter may be short- lived. CHNY is therefore asking the City to issue an RFP for two programs to serve homeless youth with severe mental or behavioral health needs that would include on-site clinical services, access to 24/7 mental health care, and intensive case management.

Int 1019-2023- Creation of a Database and Interactive Map of Mental health Services

Creation of new beds and services will only be helpful if those seeking services and their advocates are aware of them. We therefore strongly support Intro 1019-2023 which will create a database and interactive map of outpatient mental health service providers. We recommend

however that respite/crisis beds, as well as long-term mental health beds, also be included. This interactive map should be updated in real time alerting people to service availability and eligibility requirements. This would reduce the occurrence of people in distress showing up and seeking help at locations where they cannot receive services. A sense of safety and trust of adult staff is essential for youth to be active participants in the creation of their long-term wellness plan, but trust and a sense of safety may need more than 7 days to build.

Loan Forgiveness and Increased Pay for Mental Health Professionals Serving Vulnerable Populations

These new beds and services will require additional high quality mental health professionals across NYC. We simply cannot make headway with the current mental health crisis without highly trained and educated mental health professionals who are passionate about providing mental health care to vulnerable populations. Low salaries and high debt, including student loans, are creating a shortage of mental health professionals at a time when we need them most. CHNY therefore strongly support Resolution 0583-2023 which calls on NYS to subsidize the education and licensing costs of CUNY students who commit to working in mental health professions which historically experience high turnover rates and staffing shortages. We encourage SUNY and private universities who care about the health of their city to provide the same debt forgiveness.

Unfortunately, NY City and State continue to underfund social services for vulnerable populations. Sadly, it is the human services workforce, including social workers and other mental health professionals, who bears the brunt of the inadequate funding and low and stagnant wages. Insufficient state and city funding lead to turnover rates in parts of the nonprofit sector that are over 40%. High turnover rates are detrimental to the young people we serve as it is important that our youth develop a rapport with the adult staff who act as mentors and guides as they rise out of poverty. Frequent staff changes can disrupt that rapport and make it more difficult for youth experiencing homelessness to effectively address their mental health and leave poverty behind. We are requesting a 6.5% COLA increase for all frontline human services workers, in line with the ask of the #JustPay Campaign

Mental Health Needs of Migrant Youth

As we all know, in addition to a mental health crisis, NYC is in the middle of an immigration crisis with thousands of new arrivals from Central and South America. At CHNY, we have seen over 125 of these young people since this crisis started. In comparison, we often only served less than 10 undocumented or non-English Speaking youth in previous years. Almost all of these new arrivals to our city have faced the trauma of starvation, neglect and violence in their home countries. Many have recounted treacherous journeys, including the witnessing of multiple dead bodies on their way to the U.S. As these newcomers may be with us for years to come, it is essential that we do not forget their health and welfare in our city's mental health roadmap. Service providers across the city are in desperate need of Spanish speaking social workers and other mental health professionals.

911 Response to Mental Health Emergencies

When one of our young people needs a level of mental health care that we cannot provide and are in imminent danger of hurting themselves or are actively hallucinating, we have no choice but to call 911. We do so in the hopes that EMTs will take the youth to an appropriate hospital for a psychiatric evaluation and potential treatment. However, every time we call 911 in these situations, a team of NYPD officers arrives before the ambulance. Sometimes as many as X officers are dispatched to our building. Although we appreciate the officers' concern for our staff and community safety, the presence of a large numbers of officers often escalates an already tense situation and causes additional, unnecessary trauma for the youth in crisis. It also disrupts the environment for all of the young people who call Covenant House their home. We are therefore calling on NYC to expand the Be Heard Program to Manhattan. Such an expansion would enable the mental health crises of our young people to be treated as the health problems that they truly are instead of public safety issues that law enforcement often perceives them to be. More about the B-Heard Program can be found here. 911 Mental Health Response - Mayor's Office of Community Mental Health (cityofnewyork.us)

I thank you again for the opportunity to testify today.

Jayne Bigelsen
VP of Advocacy
Covenant House New York
jbigelsen@covenanthouse.org

Droste Mental Health Services, Inc
Empowering Resilience and Healing Within

171 Madison Avenue, Suite 400
New York, NY 10016
212-889-4042
drostemhservices.org

May 7, 2023

Thank you to Chair Lee and the Committee on Mental Health, Disabilities and Addictions for the opportunity to testify on the financial and logistical challenges faced by those with mental health challenges and the providers that seek to serve them, and how the Council's Mental Health Roadmap Legislative Package seeks to meet these needs. I am Sarah Strole, LCSW, Executive Director of Droste Mental Health Services, Inc. As a licensed mental health practitioner with over a decade of experience working in New York City, and a member of this community, I express my strong support for Res. 0589-2023, Res. 0584-2023, Res. 0587-2023, Res. 0592-2023, and Int. 1019-2023, and suggest a more immediate avenue for achieving the goals outlined in Res. 0583-2023.

Droste Mental Health Services, Inc. is a non-profit wellness center located in midtown Manhattan serving clients of all ages and identities throughout New York via in-person and telehealth therapy. We provide individual, group, family, and couples counseling. Our mission is to provide convenient, affordable, and inclusive psychotherapy and trauma-informed counseling. We provided over 3,000 sessions to a total of 345 clients in 2022 with our lowest fee set at 1/5th of the market rate.

Mental health is a critical aspect of overall well-being, and access to affordable and high-quality mental health care is essential for individuals and families to thrive. Unfortunately, prohibitive costs and a lack of sufficient access to providers leave many families and individuals without the care and support they need. Particularly for those who are uninsured or underinsured, the inability to obtain prevention and supportive services can have devastating consequences, leading to untreated mental health conditions and increased rates of homelessness and suicide. Access to mental health care will improve the lives of individuals and the communities in which they live, reduce the strain on emergency services, decrease the rates of substance abuse and crime, and increase overall productivity and economic stability.

Suicide Prevention:
At Droste Mental Health Services, Inc, we are seeing increases in suicidal ideation reported by our clients. The 988 hotline is a crucial component of our safety plans for clients struggling with suicidal ideation. While the national implementation of the 988 hotline is a vital step in addressing the rising rates of suicide in the United States, its reliance on routing calls using area codes over geolocation can delay interventions when callers are directed to a call center that is not in the same state or region. In large cities like New York, where many people move from other areas but still have cell phones with area codes from their hometowns, delay can be fatal. Routing calls based on geolocation would cause calls to be directed to a call center based on the caller's actual location, allowing local emergency personnel to be dispatched more quickly to provide faster attention in life-or-death situations when time is of the essence. The fulfillment of the Council's call in Res. 0589-2023 will provide our clinicians the peace of mind that when clients in crisis use the 988 hotline, they will receive the emergency help they need without unnecessary delay.

Mental Health Workforce Shortages:

Droste Mental Health Services, Inc
Empowering Resilience and Healing Within

171 Madison Avenue, Suite 400
New York, NY 10016
212-889-4042
drostemhservices.org

At Droste Mental Health Services, Inc, we see committed providers feeling forced to leave mission-based work to go to the private sector. Often, this transition happens when providers start to have families and need more financial stability, benefits, better work/life balance, and less stress. The private sector often provides more financial stability with higher salaries and annual salary increases. While high turnover rates among mental health professionals in non-profit and government positions is undeniable, research has shown that higher salaries and competitive benefits are an even more effective way to retain employees than only providing education subsidies. Education subsidies do not solve high turnover at the agency level, just that individuals will remain in the public sector in New York. By refining Res. 0583-2023 to call for providing pay parity and requiring benefits commensurate with the private sector, individuals can remain in mission-based work without sacrificing financial stability or, often, the ability to start a family.

Making Practice Possible Across State Lines

In today's increasingly mobile society, it is more important than ever for mental health practitioners to be able to practice across state lines. Many individuals move frequently for work, family, or personal reasons, and may need to seek mental health care while living in a different state. Employers increasingly require employees to travel, often for weeks at a time, while often enduring long hours and intense levels of stress. At these times, it is most important for people to have access to a mental health practitioner with whom they have built the trusting relationship necessary to provide quality mental health support. By allowing practitioners to practice across state lines as called for in Res. 0584-2023, we can ensure that mental health care services are not disrupted simply because someone must travel or relocate.

The COVID-19 pandemic has allowed us to see how permitting practitioners to practice across state lines improves client outcomes. Facing the prospect of therapy being interrupted for more than 70% of our clients, Droste Mental Health Services, Inc was instead able to serve an unprecedented number of people. Even now, every month, traveling for work or leisure disrupts therapy services for at least 15% of our clients. Enhancing the portability of mental health providers' licenses can also expand care to underserved areas struggling with a lack of practitioners or specialists, including those who speak languages other than English. Practitioners licensed in other states can bring much-needed care to these underserved areas and help reduce the burden on local mental health care providers.

Enforcing Insurance Parity:

As the Council states in Res. 0587-2023, the enforcement of mental health and substance use disorder insurance parity is critical to ensuring that individuals have access to the care they need. Expanding enforcement of insurance parity can help reduce the stigma associated with mental health and substance use disorder treatment. When insurance companies limit access to mental health and substance use disorder treatment, it sends a message that these conditions are not as important or legitimate as physical health conditions. By enforcing insurance parity, we can send a message that mental health and substance use disorder treatment is just as important as physical health care, and that individuals deserve access to care that is on par with coverage for physical health care.

Additionally, expanding enforcement of insurance parity will increase access to mental health care. At Droste Mental Health Services, Inc, the majority of people we see seeking mental health care cannot afford to pay for therapy out of pocket and depend on insurance to cover the cost of mental health services. Without enforcement

Droste Mental Health Services, Inc
Empowering Resilience and Healing Within
171 Madison Avenue, Suite 400
New York, NY 10016
212-889-4042
drostemhservices.org

of insurance parity, many of these people do not have the benefits they need to access affordable mental health care.

Increasing Medicaid Reimbursement:
The Council's call in Res. 0592-2023 for expanding the availability of mental health professionals for low- and moderate-income New Yorkers is critical to ensuring that everyone has access to the care they need. Unfortunately, many individuals cannot access care due a shortage of mental health professionals who accept Medicaid. Low reimbursement rates can cause providers to limit Medicaid cases, or alternatively stretch themselves too thin with high caseloads to cover overhead expenses, in either case impacting the quality of care and decreasing practitioners' ability to respond to crises and other needs. This puts Medicaid patients, who tend to have lower incomes, higher risks, such as elevated levels of stress and trauma, and more complex needs, at particular risk.
In addition to low reimbursements, the increased financial and administrative burdens imposed by Medicaid lower provider utilization and decrease patient access to care. Complex billing procedures require staff or external billing specialists with specific expertise, and investments in electronic health record platforms that are often prohibitively expensive for all but the largest practices. Audits, while necessary for quality control, are time and cost-intensive, drawing human and financial resources away from care. As a result, many providers stay out-of-network, requiring clients to pay out-of-pocket (a nearly impossible ask for even middle-income individuals).
Increasing Medicaid reimbursement rates for behavioral health services in line with Res. 0592-2023 would help address the primary drivers of 3his provider shortage and ensure that individuals have access to the care they need.

Mapping Mental Health Care:
Outside of finances, most of the clients served at Droste Mental Health Services, Inc. cite finding a provider as one of the top three barriers to starting therapy. Having a comprehensive database and interactive map of outpatient mental health service providers in New York City, as called for in Int. 1019-2023, would address this barrier. This database and interactive map should feature easy ways to filter providers by cost, accepted insurance, and waitlist status. It is equally important for these tools to maintain up-to-date provider lists. We had one client who called over 20 providers on the list provided by their insurance, all of whom were either no longer accepting clients or had months-long waitlists.

Conclusion:
Thank you again for the opportunity to submit testimony today. By adopting the resolutions and local laws listed above, and amending Res. 0583-2023, we can continue to build a healthier, more resilient, and more equitable New York City community for everyone.

Sarah Strole, LCSW
Executive Director
Droste Mental Health Services, Inc

FOUNTAIN
HOUSE

Fountain House Written Testimony for the 5/4 Hearing Held by the Committee on Mental Health, Disabilities and Addiction

---

Fountain House is very grateful to the Council for all your work on improving NYC's mental health care system and excited by much of what we are seeing proposed in the first ever mental health roadmap released a week ago. We wholeheartedly agree that, while COVID-19 has exacerbated the City's mental health crisis, these issues have been around far longer and are a result of long-term divestment from holistic care. As such, in order to adequately address the issues and meet New Yorkers growing mental health needs, we need a comprehensive, well-resourced continuum of mental health care that is informed by the people it is intended to serve.

We appreciate that the Council's roadmap includes investments in prevention, community-based care, bolstering the mental health workforce, increasing public awareness of available services, and more. Tackling the complex and overlapping mental health needs of New Yorkers will require numerous approaches and, as the roadmap points out, better interagency coordination of care.

We wanted to comment on two specific aspects of the Council's plan in this written testimony: one is the investments in crisis response services and the other is the legislation proposed by Council Member Riley regarding expansion of clubhouses across the City.

As part of this testimony, we have attached our new report, "Rebuilding the Mental Health Crisis Response System in New York City." Importantly, our report is based on the insights and recommendations of more than 100 Fountain House members and reflects a power-sharing approach that supports people with lived experience in analyzing and advocating for the policy changes that could protect and improve their lives. It calls attention to the rare opportunity New York City has right now to leverage historic levels of state and federal 988 funding to improve our approach to mental health emergencies: a move that can save lives, bolster public safety, and help prevent mental health crises in the first place. We look forward to working with the Committee and entire Council on implementing these recommendations this year and over the next few years.

But, we also recognize that mental health care doesn't just start and stop at the moment of crisis, so we also need to invest in community mental health programs, including clubhouses, that practice early intervention and help restore people's agency, dignity, and thriving as a meaningful pathway to recovery.

We are very encouraged to see Council Member Riley's introduction of a local law that points to the City's commitment to expanding clubhouse for people living with serious mental illness (Int. No. 1022). Specifically, the legislation seeks to advance a pilot program to ensure that these community centers are in at least five of the highest-need areas.

Fountain House Bronx currently serves many members in a very high-need neighborhood in the Bronx. The Bronx has the highest prevalence of serious psychological distress in NYC, especially concentrated in the South Bronx. Bronx residents face higher rates of unemployment, challenges with poverty and numerous health disparities, including a critical lack of mental health services.

Ten years ago, we launched Fountain House Bronx to plant ourselves in this area of greatest need. Over the past decade in this small two-story firehouse, we have greatly impacted the lives of many Bronxites with SMI. But our ability to serve more people and offer a vast array of services is limited by spatial constraints and dated infrastructure. In order to continue reaching New Yorkers living with SMI, we need a larger clubhouse.

We have plans to expand that include developing a new 17,000 square foot clubhouse and a residential building with 30 studio apartments. The clubhouse will serve 4x the number of people currently served by the Bronx clubhouse and will provide lasting connections and membership for people for lifetimes and generations.

The new building will have five floors for our holistic mental health programming, all fully accessible to people with physical disabilities. Program space includes a teaching kitchen and dining room, open space for group work, a small office for small group work, a media studio, horticulture space, a gym, a conference room and a library. In addition, there will be access to a yard and rooftop garden; this kind of green space has immense therapeutic value to our members.

We are deeply passionate about continuing to close the gap in service shortages across the Bronx through our innovative programming and would like to work with the Council to make this expansion a reality.

Thank you very much for reading this and for your consideration.

Rebuilding the Mental Health Crisis Response System in New York City

A public policy road map created by the members of Fountain House

April 2023

This road map was created in partnership with HR&A Advisors and with support from Trinity Church Wall Street Philanthropies.

Contents

Executive Summary	2
Overview	4
Approach Solutions shaped by those closest to the challenge.	9
Potential Impact Transition from law enforcement-led to health-led responses to mental health crises. Faster, more reliable responses through the 988 system. Close long-standing gaps in trust.	10
Implementation Road Map Step 1: Through 988, build a real alternative to 911 for mental health crises. Step 2: Encourage New Yorkers to reach out to a trusted, well-resourced 988 system for all mental health crises, diverting as many calls as possible from 911 to 988.	18
Conclusion Laying the foundation for a safer, healthier New York City.	29
Appendix Three ideal 988 user experiences.	30

Executive Summary

Over the next several years, New York City has an extraordinary opportunity to rebuild its mental health crisis response system to better meet the needs of people living with serious mental illness (SMI).

As our country continues to recover from the COVID-19 pandemic, mental health care needs have reached unprecedented levels among people of all ages. In response, there is a bipartisan commitment to increasing funding for mental health solutions on the national, state, and local levels. President Joe Biden has pledged a nearly $1 billion investment in the mental health crisis continuum. This significant federal investment supports the new 988 mental health crisis hotline, an alternative to 911 that was rolled out nationwide in summer 2022.[1]

Fountain House, a voluntary therapeutic community of 2,000 members living with SMI, urges the City of New York to fully seize the potential of this historic level of federal and state funding. Many of our members have interacted with mental health crisis response services, so the urgent need to improve crisis response is personal for us. As we articulated in our framework *From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response*, cities often deploy public safety and enforcement resources during mental health crises instead of health, mental health, and social support. The result is trauma, drawing people into repeated cycles of punishment and institutionalization, and needlessly fatal interactions with law enforcement.

If New York City leverages the full potential of this investment, we can turn a broadly supported vision into reality: We can replace a public safety and enforcement approach to mental health crises with a system that is managed and staffed by trained mental health professionals and peers, with the capacity to dispatch in-person care teams quickly and connect people to the community-based treatment and social service support that will help them to stabilize and prevent future crises.

More than 100 Fountain House members shaped the recommendations in this policy road map. In the next two city budgets, we recommend that the City of New York accelerate the transition from 911 to 988 by taking the following steps:

[1] The federal government has invested nearly $1 billion into 988 across the country, with New York state securing $7.2 million for implementation planning and 988 infrastructure investments. The state has also included $35 million in its fiscal year 2023 budget, which will increase to $60 million on a full annual basis starting in fiscal year 2024. New York City received $10.8 million of this funding to answer up to 500,000 calls, texts, and chats from New Yorkers between July 2022 and July 2023.

STEP 1 **Through 988, build a real alternative to 911 for mental health crises.**	In the next year, we urge the City of New York to work quickly to close trust and service gaps in the current 988 system so that the people making the approximately 95,000 crisis calls that come into the 988 system every year have access to: 1. A peer or mental health professional they can speak to within seconds instead of minutes. 2. A mental health response team that can come to them within minutes instead of hours, day or night. 3. Access to short-term respite and other community-based hospital alternatives within hours instead of weeks or months. 4. Real, ongoing support in the community after a crisis. 5. Smoother integration into the social service system so that people calling 988 can access other city services that address housing, financial, and benefits stressors without facing bureaucratic hurdles. 6. Increased trust, because the City of New York has established a Peer Oversight Board to provide guidance and accountability for the mental health crisis response system.
STEP 2 **Encourage New Yorkers to reach out to a trusted, well-resourced 988 system for all mental health crises, diverting as many calls as possible from 911 to 988.**	If the City of New York adopts the recommendations in this paper to make 988 a trustworthy, well-resourced, responsive system, we urge it to move as many calls out of the 911 system and into the 988 system as possible. To do this, the city should: 1. Scale service capacity within the 988 system so that calls can be answered within seconds, mobile treatment teams can respond within minutes, and people experiencing a crisis can be connected to community-based care within hours. 2. Continue to improve trust in the 988 system by working with the Peer Oversight Board to create clear and transparent guidelines for responding to mental health crises that involve a weapon or imminent risk of violence and for using involuntary hospitalization as a last resort. 3. Invest in significant public education campaigns to encourage people to reach out to 988—not 911—for help during mental health crises.

By implementing the recommendations in this road map, the City of New York could improve public safety, prevent mental health crises, and save lives.

Overview

Unprecedented national attention

As our country continues to recover from the COVID-19 pandemic, mental health care needs have reached unprecedented levels among people of all ages. Right now, considerable national, bipartisan attention is focused on finding ways to meet these needs, such as building new care systems and expanding the behavioral health workforce.

A central pillar of the federal government's strategy is to allocate nearly $1 billion for the mental health crisis continuum. This significant investment is intended to support more local capacity to answer crisis calls through the new 988 mental health crisis hotline, and to expand community-based mobile crisis response teams and community-based facilities to provide stabilizing care during and after a crisis, thereby reducing the need for unnecessary emergency department visits. According to the Biden administration, the goal of these investments is to provide "someone to call, someone to respond, and somewhere for every American in crisis to go."

Fountain House members, who are individuals living with SMI, have experienced crises and seen firsthand the good and bad aspects of New York City's crisis response system. They believe this significant new federal funding has created an unprecedented opportunity to replace the current public safety approach to mental health crises with a public health approach. By leveraging the full potential of this investment, the city can turn a broadly supported vision into reality: a mental health crisis system managed and staffed by trained mental health professionals and peers, with the capacity to dispatch in-person care teams quickly and connect people to the community-based treatment and social service support that will help them to stabilize and prevent future crises.

A significant opportunity for New York City

In March 2023, the administration of New York City Mayor Eric Adams released *Care, Community, Action: A Mental Health Plan for New York City*, a sweeping mental health agenda that explicitly acknowledges an emerging consensus that mental health crises should be treated through the public health system, not through the public safety system. It states:

> "The entry way to our SMI care systems is often through emergency response systems [such as 911], the majority of which have been led by law enforcement. Law enforcement and mental health advocates agree this situation is not ideal, and would prefer more clinically and health-led responses to mental health crises."

Fountain House's members and staff vehemently agree that New York City should have health-led responses to mental health crises. However, to date the city has not acted quickly or boldly enough to rebuild its mental health crisis response system to better meet the needs of people living with SMI.

New Yorkers living with SMI should be able to turn to a mental health crisis system they can trust when they need help. Right now, Fountain House's members say that trust is frayed. For decades, the city has almost exclusively invested in police and ambulances as the only 911 dispatch option for people who need in-person, mental health help within minutes. Because these responders are not trained to de-escalate a mental health crisis or deliver on-site mental health care, they transport nearly everyone to a hospital. That approach is unnecessarily costly, and often traumatizing.

The city's overreliance on police and ambulances to respond to mental health crises has had profound consequences. One Fountain House member said, "If you are struggling, the police's first reaction is to rough you up, take you to the hospital, then they release you back to the same situation where you started."[2] Fountain House's members repeatedly shared that when police with little or no training in how to interact with someone experiencing a mental health crisis arrive with lights, sirens, and weapons, they escalate a situation, when what is urgently needed is de-escalation and calm. Members feel that the lights, sirens, and guns bring them unwanted attention, make them feel like they did something wrong by seeking help, and can be physically dangerous.

According to the Biden administration, the goal of recent federal investments is for every person experiencing a mental health crisis to have "someone to call, someone to respond, and somewhere to go." New York City has significant work to do to meet this national goal. Right now, its 988 system does not have the capacity to offer an in-person response within minutes to people experiencing an acute mental health crisis. If people need help quickly, their only reliable option is to call 911.

- In New York City, calls to 988 are answered by NYC Well, the local version of the 988 Suicide and Crisis Lifeline, which is operated by Vibrant Emotional Health, a nonprofit organization the city has contracted with to provide this service. While many calls are answered quickly, some people who call 988 for help still must

[2] Member quotes in this report were transcribed during conversations with HR&A and have been lightly edited for context and clarity.

wait several minutes before a call taker answers,[3] suggesting the need for more funding to support enough staff to meet the demand.

- If the call taker sends a mobile crisis team to deliver in-person care to someone experiencing a crisis, the team could take hours to arrive.

- If the mobile crisis team facilitates a connection to stabilizing care, the person in crisis may have to spend weeks or months on a waiting list before they can be served by a respite center or ongoing mobile treatment team.

Our recommendations for rebuilding New York City's mental health crisis response system

Over the next few years, New York City has an opportunity to leverage the historic levels of state and federal 988 funding to create a new mental health crisis response system, anchored in 988, that is fully designed by health experts and people with lived experience and that delivers the immediate help people need.

With this new system, health professionals, not police, would respond to mental health crises within minutes, and people would receive care in their homes and communities instead of in hospitals. Once this new 988 system is built, the city should move as many mental health calls as possible out of the 911 system and into the 988 system.

This policy road map lays out a strategy that will allow New York City to close its 988 system's gaps in service and trust and build a real alternative to 911. The new system would have the capacity to handle the approximately 95,000 crisis calls already coming into the 988/NYC Well system annually and most of the approximately 170,000 mental health crisis calls coming into the 911 system annually, and to help the unknown number of people who, right now, will not reach out to city services during a mental health crisis because they do not trust the city to protect their safety and agency.

Specifically, we recommend the following two-step operational strategy:

[3] Across the country, the National Suicide Prevention and Crisis Lifeline has received more calls and answered calls more quickly following the transition from a 10-digit number to 988 and significant federal investment to support 988 implementation. In New York state, according to the most recent data, 79% of calls to 988 were answered in-state in February 2023 while 10% of callers hung up before their call was answered. The average statewide answer time in February 2023 was 28 seconds; leaders overseeing the 988 Suicide and Crisis Lifeline have said their goal for 988 is that, eventually, 95% of calls will be answered within 20 seconds. The New York State Office of Mental Health (OMH) has found that New York City's 988 system has capacity challenges that result in delays in answering some calls. When the system is unable to answer, callers are directed to a national backup crisis center—another national 988 Suicide and Crisis Lifeline, according to OMH. A February 2022 report from OMH says calls to 988 are less frequently answered in New York City than in the rest of the state: Calls from Manhattan, Brooklyn, Queens, and the Bronx have a higher likelihood of being routed out of state than those in most counties in New York. This suggests that New York City's 988 system needs more counselor and peer staff capacity.

STEP 1 **Through 988, build a real alternative to 911 for mental health crises.**	In the next year, we urge the City of New York to work quickly to close trust and service gaps in the current 988 system so that the people making the approximately 95,000 crisis calls that come into the 988 system every year have access to: 1. A peer or mental health professional they can speak to within seconds instead of minutes. 2. A mental health response team that can come to them within minutes instead of hours, day or night. 3. Access to short-term respite and other community-based hospital alternatives within hours instead of weeks or months. 4. Real, ongoing support in the community after a crisis. 5. Smoother integration into the social service system so that people calling 988 can access other city services that address housing, financial, and benefits stressors, without facing bureaucratic hurdles. 6. Increased trust, because the City of New York has established a Peer Oversight Board to provide guidance and accountability for the mental health crisis response system.
STEP 2 **Encourage New Yorkers to reach out to a trusted, well-resourced 988 system for all mental health crises, diverting as many calls as possible from 911 to 988.**	If the City of New York adopts the recommendations in this paper to make 988 a trustworthy, well-resourced, responsive system, we urge it to move as many calls out of the 911 system and into the 988 system as possible. To do this, the city should: 1. Scale service capacity within the 988 system so that calls can be answered within seconds, mobile treatment teams can respond within minutes, and people experiencing a crisis can be connected to community-based care within hours. 2. Continue to improve trust in the 988 system by working with the Peer Oversight Board to create clear and transparent guidelines for responding to mental health crises that involve a weapon or imminent risk of violence and for using involuntary hospitalization as a last resort. 3. Invest in significant public education campaigns to encourage people to reach out to 988—not 911—for help during mental health crises.

We recognize that it could take a decade to transition fully from the 911 system to the 988 system. New York City has a profound shortage of mental health and peer workers, and scaling services within the 988 system will require long-term planning and significant investment in training and fairly compensating this critical workforce. Additionally, some efforts are underway to improve the 911 system, such as crisis

intervention training for NYPD officers and the B-HEARD program, which dispatches social workers and emergency medical technicians instead of police to respond to nonviolent 911 mental health calls. However, Fountain House believes the city's mental health crisis response system should be one in which:

- Every person in crisis has access to a health-led response.
- The City of New York takes every step possible to avoid unnecessary hospitalizations and instead connect people to stabilizing community-based care.
- The City of New York takes every step possible to avoid violence, traumatization, and jail bookings. Our crisis response system should be the front door to ongoing care, not to punishment and institutionalization.

This policy road map provides steps the City of New York should take in fiscal years 2024 and 2025 to accelerate the transition from the 911 system to the 988 system. If these steps are implemented, the city could lay a foundation for more safety, fewer mental health crises, and better outcomes for New Yorkers living with SMI.

Approach

Solutions shaped by those closest to the challenge

This public policy road map was developed by the members of Fountain House, who are individuals living with SMI; trained social practitioners who provide members with daily support in the organization's clubhouses; and analysts from HR&A, an employee-owned, mission-driven public policy and economic development advisory firm. Fountain House takes a public health approach to SMI that addresses both the health and social needs of its members through an integrated model that connects a physical clubhouse, where members are engaged in an innovative therapeutic community rooted in social practice and take steps in reclaiming their agency and dignity, with access to clinical support, housing, employment and education opportunities, and care management.

Fountain House has two clubhouses in New York City—direct service locations in Hell's Kitchen and the South Bronx—that engage 2,000 members, 40% of whom have been unhoused, a quarter of whom have been involved in the criminal legal system, and many of whom have had some interaction with the city's mental health crisis response system. Fountain House's approach is a solution to these realities: Within a year of joining the organization, our members are twice as likely to be employed, have better educational attainment, and an increased likelihood of being stably housed compared with others living with SMI. A study from New York University also found that Fountain House members have 21% lower Medicaid costs than their peers, largely due to the holistic benefits of psychosocial rehabilitation.

To develop the analyses and recommendations in this road map, more than 100 Fountain House members described to HR&A their experiences with the current mental health crisis response system and their ideas for rebuilding it to better serve people living with SMI. HR&A's staff directly engaged with members in Fountain House's therapeutic community: Social practitioners, who work with members to reclaim their emotional, cognitive, and social skills and get holistic support in all aspects of their lives, co-facilitated every interview and focus group, and the HR&A team was integrated into trusted environments within the clubhouses, such as the culinary and communications units.

Fountain House is intentionally designed to involve its members in all aspects of clubhouse management, including public policy and advocacy. This road map and the process used to develop it reflect a power-sharing approach to supporting people living with SMI, enabling them to analyze and advocate for the policy changes that could protect and improve their lives.

Potential Impact

Right now, New York City has an immediate opportunity to leverage significant federal and state investment to increase health-led responses to mental health crises. In the summer of 2022, New York City—along with the rest of the country—launched 988, a three-digit number designed to provide help during a mental health crisis. The federal government and the state of New York have pledged tens of millions of dollars to New York City to support 988 implementation over the next several years.[4]

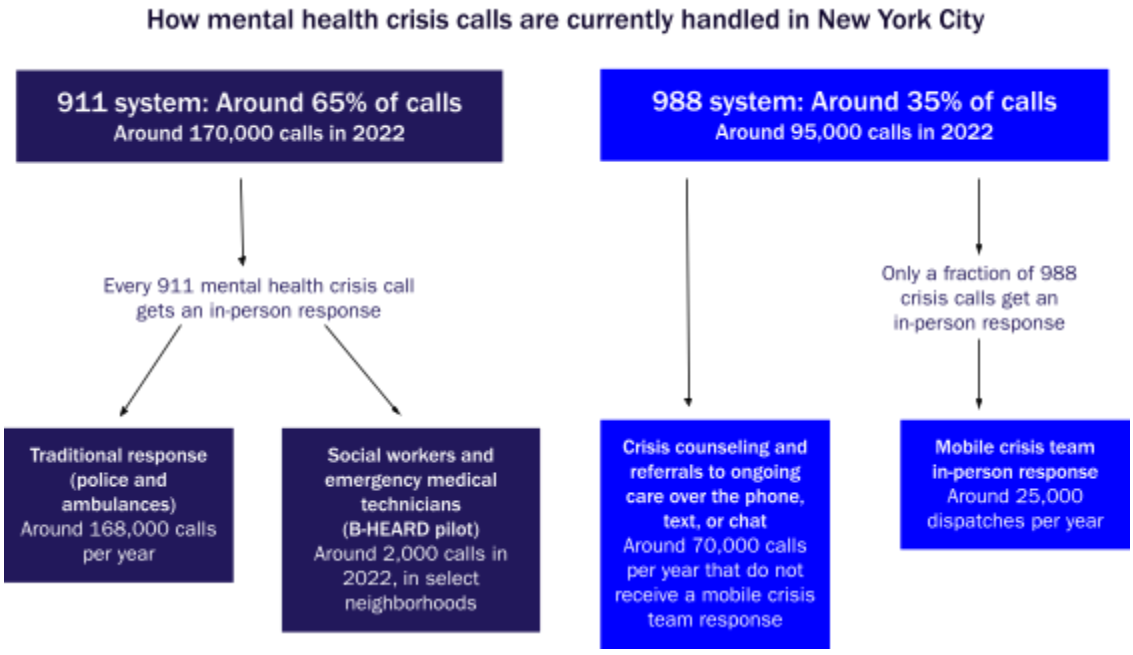
If the City of New York fully seizes the potential of this federal funding, it could accelerate three important system changes: the transition from law enforcement-led to health-led responses to mental health crises; faster, more reliable responses through the 988 system; and the closing of long-standing gaps in trust in the mental health response system.

System Change 1: Transition from law enforcement-led to health-led responses to mental health crises

Hundreds of people experience mental health crises in New York City every day.[5] Given the limitations of data, the primary way we can measure how many occur is by the number of crisis calls that come into the 911 and 988 systems.

[4] The federal government has invested nearly $1 billion in 988 across the country, with New York state securing $7.2 million for implementation planning and 988 infrastructure investments. The state has also included $35 million in its fiscal year 2023 budget, which will increase to $60 million on a full annual basis starting in fiscal year 2024. New York City received $10.8 million of this funding to answer up to 500,000 calls, texts, and chats from New Yorkers between July 2022 and July 2023. The Biden administration's fiscal year 2024 budget, released in March 2023, pledges an additional $559 million to the 988 Suicide and Crisis Lifeline to address 100% of estimated contacts, scale up follow-up crisis services, and expand suicide prevention programs to all states, the District of Columbia, and 18 tribal and territorial jurisdictions.

[5] For the purposes of this paper, a "mental health crisis" is defined in three ways: any call that comes into the 911 system and is categorized as a "mental health call"; a risk level 5, 6, or 7 call (as described in the independent evaluation of the NYC Well system from Abt Associates, a risk level 5, 6, or 7 "crisis" call involves active suicidal or homicidal ideation); and the unknown number of people who experience mental health crises but do not reach out to city services. In addition to crisis calls, the 988/NYC Well system receives hundreds of calls, texts, and chats every day from individuals who are seeking mental health support and connection to services but are not experiencing an active crisis.



1. The majority of mental health crisis calls in New York City come into the 911 system, which received around 170,000 mental health crisis calls in 2022, or about 465 calls per day.[6] Every mental health crisis call that comes into the 911 system receives an in-person response, the vast majority from police and ambulances. In some neighborhoods, 911 operators will dispatch teams of social workers and emergency medical technicians instead of police to respond to mental health calls that do not involve a weapon or an imminent risk of violence. These teams are part of the B-HEARD pilot program, which began in June 2021. Traditional 911 responses and B-HEARD teams respond within around 15 minutes citywide.

2. Vibrant, the nonprofit New York City has contracted with to operate the NYC Well helpline to which 988 calls are directed, receives about 1,300 calls, texts, and chats daily from New Yorkers seeking mental health support. According to an independent evaluation of the NYC Well helpline from Abt Associates, about 20% of these calls are from people experiencing a crisis. This means Vibrant receives about 260 crisis calls every day, just over half as many as 911. Of these crisis

[6] The most recent reported full year data is from 2022, reported in the *New York Times*. According to testimony from the Mayor's Office of Community Mental Health: "From 2008 to 2018, the number of 911 mental health calls nearly doubled from 98,000 calls in 2008 to 170,000 calls in 2018. Now, the tide is turning. In 2019, 911 mental health calls went down by 4% for the first time in a decade to 163,000 calls. And in 2020, they went down even more by another 6% to 153,000 calls." An article in the *New York Times* reported that the City of New York's 911 system received 139,000 911 mental health crisis calls between January and the end of September 2021, which may suggest that the number of 911 mental health calls increased in 2021 compared to 2020.

calls, about 25% (or 25,000 per year) receive an in-person response from a mobile crisis team. Mobile crisis teams can respond within two hours citywide and are operational from 8 a.m. to 8 p.m.

In 2019 and 2020, the number of mental health crisis calls coming into the 911 system fell, the first decline following a decade in which 911 mental health calls increased every year and in every precinct in the city. Encouragingly, during the same period the number of calls to 988/NYC Well grew. According to the independent evaluation of NYC Well, many callers are seeing NYC Well as an alternative to traditional emergency services. Twenty-three percent of surveyed NYC Well users, including both those contacting the program on their own behalf and those contacting on behalf of someone else (e.g., a friend or family member), reported that if not for NYC Well, they would have considered calling 911 or going to an emergency room.

These trends suggest that a transition from the 911 system to the 988 system is possible—and that New York City may have been headed toward this transition before the COVID-19 pandemic. There is also reason to believe that the 988 system could be trusted and effective. Abt's independent evaluation of NYC Well found that nearly 90% of people who used the helpline reported that they received assistance in dealing with their problems. However, this finding was for all NYC Well users, not specific to NYC Well users who called the helpline during a crisis. Additionally, the evaluation found that a diverse range of New Yorkers are reaching out to NYC Well—30% of callers identified as Black or African American, 18% as other, 8% as Asian, and 8% as multiple races. In response to a separate question about ethnicity, 26% of callers identified as Hispanic.

In 2022, the number of 911 mental health calls increased to approximately 170,000 from approximately 150,000 in 2021. This uptick in 911 mental health calls, following two years of decline, suggest the need for a more intentional effort from the City of New York to divert mental health crisis calls out of the 911 system and into the 988 system. In its New York State 988 Implementation Plan, OMH estimates that "30% of 911 calls [will be] diverted to 988." We encourage the City of New York to implement the recommendations in this report to accelerate the transition away from 911 and to 988 for mental health crises.

System Change 2: Faster, more reliable responses through the 988 system

During a mental health crisis, a person might experience profound confusion and paranoia. Or a mother may worry that her child will hurt herself. Like anyone having or witnessing a physical health emergency, such as a stroke or heart attack, these New Yorkers need to access the right kind of medical attention as quickly as possible.

Yet in New York City, mental health care is hard to find—before, during, and after a crisis. Every day, New Yorkers facing mental health challenges linger on waiting lists for

community-based clinics or respite care and have trouble finding providers who are in their neighborhoods, accept Medicaid or their insurance, or speak their language. The most recent data from the New York City Department of Health and Mental Hygiene (DOHMH) shows that half of the nearly 500,000 New Yorkers who experienced serious psychological distress in the past year did not get the medication or treatment they needed. The truth is that there are too many barriers preventing access to the ongoing, community-based mental health care that can help people avoid a crisis or stabilize after one.

Without adequate or affordable mental health care in our communities, too many people are forced to rely on 911 and emergency rooms. DOHMH reports over 75,000 mental health emergency department visits per year in which the individual seeking care was discharged to the community. According to DOHMH, these patients likely ended up in the emergency department because they faced "barriers to appropriate and relevant community care," and these emergency department visits are "costly and potentially preventable."

Sadly, overreliance on the 911 system and hospitalization during a crisis follow familiar patterns of divestment and underservice. The poorest neighborhoods in our city—those many New Yorkers of color call home—have the fewest mental health clinics and more than twice as many psychiatric hospitalizations as the richest neighborhoods. Our clubhouses are strategically based in two of the neighborhoods with the greatest need, Hell's Kitchen and the South Bronx, to provide resources and support in areas where there are significantly more mental health 911 calls than on the Upper East Side or in Brooklyn Heights, for example.

Many public health programs, such as respite care or mobile crisis teams, could address the problem, says a social practitioner in the Clubhouse New York Coalition, "but these programs are all in a pilot stage—they are not available everywhere, or they are not available 24 hours a day, or they have waiting lists. Until these programs are brought to scale, we are in limbo. In an emergency, I simply do not have another option than to call 911."

Examples of promising public health programs that have not yet received sufficient investment include:

- **Mental health response teams dispatched through 988.** Mobile crisis teams of behavioral health professionals—such as social workers, peer specialists, and family peer advocates—can be dispatched by Vibrant, the nonprofit that operates 988/NYC Well, or by hospitals to provide in-home mental health care. But these teams operate only between 8 a.m. and 8 p.m., and with just 19 teams serving all five boroughs, they are stretched thin. They aim to arrive within two hours of being dispatched, significantly longer than the response time for the traditional 911 dispatch of police and ambulances.

- **Community-based alternatives to hospitalization.** In interviews, Fountain House members and social practitioners reported that hospitals often quickly discharge people experiencing a mental health crisis—meaning they are not providing care for a long enough period to help people stabilize. Members and social practitioners shared that longer-term support from community-based alternatives to hospitals are very effective. Crisis respite centers, for example, serve people who anticipate or are experiencing a mental health crisis and provide 24/7 support from trained peers, mental health care, and a temporary stay in a warm, safe, and supportive home-like environment where residents are free to come in and out of the building as they please. An independent evaluation of crisis respite in New York City found that peer-staffed crisis respite centers are an effective alternative to emergency departments, and that respite clients experienced 2.9 fewer psychiatric hospitalizations in the month of respite use and the 11 following months than would have been expected without the intervention. However, New York City has lost half of its crisis respite centers since 2019. Just four health department community partners are operating respite centers for adults, and each is able to serve around 10 people at any given time. This results in a small number of respite beds and waiting lists that can be weeks or months long.

- **Stabilizing care that can help prevent repeated crises.** A November 2022 analysis from *Crain's* found that more than 1,000 New Yorkers living with SMI were on waiting lists for clinical care from city- and state-funded ongoing mobile treatment teams, which bring psychiatrists, nurses, social workers, and peer counselors to people who need comprehensive and frequent mental health and social services. Mobile treatment teams have been shown to reduce hospitalization, help clients connect to permanent housing, and limit involvement with the criminal legal system.

System Change 3: Close long-standing gaps in trust

In 2016, Deborah Danner, a 66-year-old Black woman living with schizophrenia who was a proud mental health advocate and a beloved member of Fountain House and her Bronx community, was shot and killed by police while experiencing a mental health emergency. Stories like Deborah's, of violence and trauma, steeped in racism, have become all-too-common headlines, and have made Fountain House's members fearful of calling 911. Nationwide, for every four people killed in response to an emergency call, at least one has a diagnosed SMI. Those killed are disproportionately people of color. Having a mental health emergency, particularly if you're Black, can be a frightening and sometimes deadly proposition when it comes to police encounters.

As we articulated in *From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response*, rebuilding the mental health crisis response system in New York City must be about much more than leveraging funding to add more services. The city must also ensure that its residents can trust these services—services

should be shaped and implemented by people who have lived experience with mental illness, and the crisis response system should be accountable to the people it serves.

In focus groups and interviews, over 100 Fountain House members shared the following ideas for closing gaps in trust in the mental health crisis response system and building a system that New Yorkers living with SMI would feel comfortable accessing when they need urgent help.

988 call takers should offer personalized support that quickly de-escalates the situation.

Starting with the call, members want 988 call takers to offer quality, personalized support. Members feel call takers need more training to help them effectively navigate moments of crisis, and they worry that insufficient training could cause misunderstandings. Some members said that when they have called NYC Well or 988 in the past, call takers used a script that felt impersonal and unhelpful. They asked standard questions instead of listening and responding to the caller's individual needs.

While members agreed that some basic questions are necessary to ensure a caller's safety, one member noted that the standard questions can escalate the situation: "When they ask me their standard questions, it feels like they come out of nowhere. They are sensitive questions that make the situation feel more intense." Another member shared, "When I am in a crisis, I really want someone to calm me down, tell me it is going to be OK, and ask me what I need. Once this happens, if the call taker needs to ask me a lot of questions, they should explain that they are asking because they care about my safety and want to help me get the support I need."

988 call takers should offer support for callers who may be feeling isolated.

"Crises can happen at night when you are alone, your provider is not answering the phone, and Fountain House is closed," one member said. "That's when you need someone, and you can't wait hours." Members have found comfort in picking up the phone and hearing another voice on the other end of the line—and many believe the 988 helpline could play a critical role in providing after-hours support to address isolation and loneliness.

People with SMI often have small or restricted social networks, which can increase their risk of social isolation. This not only leads to persistent feelings of loneliness, which has been associated with stigmatization, impaired social skills, and worsening symptoms, but can also increase the likelihood of psychiatric rehospitalization.

988 call takers should respect agency and choice.

Members want to choose how, when, where, and from whom they get care. Members shared their deep-seated fears about reaching out to the city for help, worrying that 988 might send police without their consent or that a mobile crisis team might force them to go to the hospital against their will. “I am scared [to call 988 because I fear they] will send the police,” one member said. “I don’t trust that they will listen to me if I am in a crisis and just need someone to talk to. Sometimes that really helps, and it’s all I need.” Members felt they need to be able to trust that when they ask for their desired level of care, 988 counselors will respect their wishes.

Fountain House’s diverse membership shared a range of perspectives on hospitalization and involuntary treatment. Some said there is real value in involuntary hospitalization in instances where it may be needed to help people become stabilized to the point where they can regain their agency, choice, and informed decision-making. “If I were to get to that point where I cannot make an informed decision about care, I would want treatment to get me stabilized,” one member said. However, members consistently said they would only want health professionals to make decisions about involuntary care. Importantly, members agree that standards for involuntary care should specify that it should be considered a last resort, not a starting place.

The 988 crisis response system must be able to connect people to effective, accessible, ongoing services.

Members want 988 to support their long-term mental health by connecting them with ongoing care they can actually access. Members said they feel exasperated by long lists of providers who do not take Medicaid, are not accepting new patients, or have a months-long waitlist. “When I am in a crisis, it makes things worse to go through a list of providers who tell me they can’t see me for six months or don’t accept my insurance,” one member said.

An independent evaluation of 988/NYC Well found that only a fraction of people who received referrals for behavioral health care through the helpline were able to make an appointment: “[Callers] expressed frustration with not being able to access the behavioral health care they needed due to the referred provider not taking their insurance or long wait times to make an appointment. Some [callers] noted that even though they were given the names of three or four potential providers, they were not able to find one that was a good fit for their personality, finances, or acuity of need.”

While the 988 funding streams are unlikely to be sufficient to address the shortage of mental health care providers in New York City, members suggested that 988 could play a more intensive care-navigation role by supporting callers until they are able to successfully make an appointment, as they said Fountain House does for them.

According to one member, "It helps having Fountain House because you know people who can help you through the process."

The 988 crisis response system must be connected to other city services that address social and economic factors that can exacerbate mental health needs.

"Just a hotline is not enough," one member said. "There are two things that make me have a crisis: no money in my pocket and no roof over my head." Members agreed that stressors in their lives—like economic insecurity, housing insecurity, job insecurity, inaccessible health care, family violence, and unsafe shelters—have profound effects on their mental health.

Members said they would find it very helpful if the 988 helpline could facilitate easy connections to other services that address some of those stressors. For example, if a person experiencing a mental health crisis that has been exacerbated by fear of eviction calls 988, the call taker should be able to provide mental health support first, then directly connect the caller to the city's support services for people at risk of eviction or entering shelter. Or if a 988 caller is having a mental health crisis exacerbated by fear of abuse from a family member or intimate partner, the call taker should be able to provide mental health support and then connect the caller to Safe Horizon's hotline, which offers safety planning and referrals to programs and services in their community.

The 988 system should address the profound stigma faced by people living with mental illness.

"I want people to treat me like everyone else," one member said. "We need community education so people's first reaction [to witnessing a mental health crisis] isn't to call the police." Members said they routinely experience stigma, and they feel like many New Yorkers see people who experience mental health issues as dangerous instead of as human beings who may need help and health care. This stigma perpetuates the overuse of 911 and the public safety system to address mental health needs. Fountain House's members said it would be very helpful to have sustained, significant public education to teach all New Yorkers to see mental health crises as public health issues, not as public safety issues. This public education could help combat stigma, and encourage people to call 988 instead of 911 if they believe someone is having a mental health crisis.

Implementation Road Map

Step 1: Through 988, build a real alternative to 911 for mental health crises.

In the next year, we urge the City of New York to work quickly to close trust and service gaps in the current 988 system so that the people who make the approximately 95,000 crisis calls that come into the 988/NYC Well system every year have access to immediate support; community-based care; and connection to other city services that address housing, financial, and benefits stressors. We also urge the city to enhance trust in the mental health crisis response system by inviting peer oversight.

Below we suggest ways the City of New York could implement these changes over the coming year, including recommended steps to take in its fiscal year 2024 budget.

A peer or mental health professional they can speak to within seconds instead of minutes.

New York City invests $22.5 million per year in NYC Well, which operates its 988 helpline. In fiscal year 2023 (July 2022 to June 2023), NYC Well received a one-time investment of $10.8 million from the New York State Office of Mental Health (OMH) as part of the rollout of the 988 helpline. This additional investment was intended to support enough call takers (counselors and peer support specialists) to answer up to 500,000 calls, texts, and chats from New Yorkers—a nearly 20% increase in capacity from the previous year.

Despite this investment, NYC Well is still struggling to consistently provide sufficient staff to answer all the calls it receives. When NYC Well is unable to answer, callers are directed to a national backup crisis center—another 988 Suicide and Crisis Lifeline—according to OMH. A February 2022 report from OMH found that calls to 988 are more frequently unanswered in New York City than in the rest of the state: 988 calls from Manhattan, Brooklyn, Queens, and the Bronx have a higher likelihood of being routed out of state than in most counties in New York, which suggests that New York City's 988 system needs more counselor and peer staff capacity.

To ensure that the 988 helpline can answer every call it receives—and do so within seconds—we recommend these actions:

- The New York State Office of Mental Health should provide recurring annual funding to New York City to support 988 expansion, and the city should increase its annual investment in NYC Well by $10.8 million to support sufficient staffing for the 988/NYC Well helpline.

- The City of New York and Vibrant should publicly report on a monthly basis the number of calls, texts, and chats received by 988/NYC Well; the percentage of calls that were not answered, either because the caller hung up after waiting too long or was routed to a call line outside of the state; and the percentage of calls, texts, and chats that were answered in under one minute. The city should commit to investing in sufficient 988/NYC Well staff capacity to ensure that all calls that come into the helpline can be answered in under one minute and increase funding for Vibrant to help it achieve this goal.

- New York City and New York state should invest in building a workforce pipeline of peer specialists and mental health providers so that 988 can recruit well-trained mental health professionals as it grows.[7] The city should also explore raising the compensation for 988 call takers to help retain this critical mental health workforce.

A mental health response team that can come to them within minutes instead of hours, day or night.

When a 988 call taker believes a crisis call should receive an in-person response, Vibrant can dispatch a mobile crisis team of nurse practitioners, licensed social workers, and certified peers who can arrive within hours and treat people in their homes. These teams are dispatched about 25,000 times per year, by both Vibrant and hospitals—meaning that about 25% of the crisis calls NYC Well receives result in a mobile crisis team dispatch. The other 75% are either resolved over the phone or, in several hundred instances per year, referred to emergency medical services if a mobile crisis team is unavailable.

[7] Currently, 988/NYC Well call takers (counselors and peers) are able to support around 10 to 12 callers per shift. With a total of around 1,300 calls, texts, and chats per day, Vibrant estimates they need about 300 full-time counselors on staff in order to offer 24-hour coverage, seven days a week.

Fountain House's members, social practitioners, and the system implementers interviewed as part of this project consistently pointed out that having mobile crisis teams operate only from 8 a.m. to 8 p.m., rather than 24 hours a day, is problematic. One system implementer said, "At night, our only option is to call 911 and attempt to send emergency medical services if someone in crisis needs an in-person response. The risk is that 911 will also dispatch police." Fountain House's members also shared concerns that mobile crisis teams could involuntarily hospitalize them or provide care that does not respect their agency and choice.

To ensure that mental health response teams can respond 24 hours a day and be trusted by the people they serve, we recommend these actions:

- New York state and New York City should partner to fund increased mobile crisis team capacity in the city. This service should be available 24 hours a day, with sufficient capacity for teams to respond within minutes anywhere in the five boroughs. While the state currently mandates that mobile crisis teams respond within several hours, we recommend that the city set an operational goal—and provide funding to enable the teams to achieve it—of a response time comparable to that of emergency medical services. New York City may be able to leverage federal funds to support this expansion: From April 2022 through April 2025, section 9813 of the American Rescue Plan Act is authorizing an enhanced 85% federal match Medicaid reimbursement for mobile crisis services. According to the New York State OMH, this expanded federal match "will offset the cost to NYS of expanding the geographic coverage and operating hours (move to 24/7 operations) resulting in a robust Mobile Crisis system that meets the needs of all New Yorkers."

- New York City should publish quarterly data on the outcomes of mobile crisis team care and on the self-reported experiences of individuals and families who received care from a mobile crisis team.

- New York City should standardize mobile crisis team transportation resources. While some teams have response vehicles, others rely on public transit. Teams with vehicles do not have the same privileges as other first responders (meaning they do not have the lights and sirens that could help them arrive to treat someone more quickly), with some teams describing delayed care because of difficulty finding parking (rarely an issue for ambulances and police vehicles). The city should invest in clearly marked mobile crisis team response vehicles that have Department of Transportation approval to park as needed, as other emergency vehicles do, to streamline their responses.

- New York City should standardize the process by which mobile crisis teams are dispatched. According to interviews with mobile crisis team providers, these teams receive dispatch requests from two sources: the psychiatric hospital with which the team is affiliated and the 988 system. Typically, 988's threshold for dispatching a mobile crisis team is higher than a hospital's, which leaves some teams responding to especially high volumes of hospital referrals, creating response backlogs and inhibiting their ability to respond quickly to new dispatch requests from 988. To help mobile crisis teams work effectively and efficiently, the city should develop clear, universal standards for both 988 and hospitals so that the teams can prioritize responses to acute mental health crises.

Access to short-term respite and other community-based hospital alternatives within hours instead of weeks or months.

Members and social practitioners reported that when people are taken to a hospital during a mental health crisis, the hospital will often release them within a few hours—meaning that the care hospitals provide is not sufficiently intensive to help people stabilize during a crisis. The quick churn in and out of emergency rooms can be stressful and traumatizing for people experiencing a crisis. The Adams administration's recent focus on increasing involuntary transports to hospitals could exacerbate these trends.

Fountain House's members widely endorse short-term, community-based hospital alternatives, such as respite care. These care options provide days or weeks of residential support

to help people stabilize after a crisis, and they are integrated into communities, which can support connection with friends, family, housing providers, employers, and ongoing mental health providers who can continue to support individuals after they leave respite care. However, respite providers report that for every person they can serve, there is at least one person on their waiting list. People often must wait for weeks or months before they can access stabilizing care.

To support community-based stabilizing care for people experiencing a crisis, we recommend these actions:

- New York state and New York City should partner to fund more respite and short-term recuperative care in the city. There is an urgent need within the next year to fully clear the waiting list for crisis respite services, which we estimate will require at least doubling crisis respite capacity. Gov. Kathy Hochul's fiscal year 2024 budget allocates $60 million in capital and $122 million annually to expand outpatient services. We recommend that the city advocate to secure some of this funding to support the expansion of mental health crisis respite care in the city.

- Crisis respite care providers report that it is very difficult for them to cover their full costs, in part because of complications when billing Medicaid. We recommend that the state and the city commit to funding respite care providers at a level that will cover the cost of care, including funding to help them cover their costs while awaiting Medicaid reimbursement.

Real, ongoing support in the community after a crisis.

Connecting to ongoing, community-based care after a mental health crisis can be a real challenge. Fountain House members reported that they have been released from hospitals without a care plan or without a care plan they can actually follow, often because of the long waiting lists for community-based care or difficulty finding a provider who accepts their insurance, speaks their language, or is located in a neighborhood convenient for them.

While the 988 system isn't and should not be responsible for addressing the shortage of affordable, accessible mental

health care providers in New York City, the system could connect people experiencing a crisis to lower-cost care navigation programs and community-based support services that can help them find care that meets their needs.

One way to do this is by using the mental health clubhouse model, as Fountain House does. We address the health and social needs of our members through a supportive community and access to clinical support, housing, and care management. Evidence for the clubhouse model is powerful: Our members are hospitalized and experience crises significantly less often than others with SMI, resulting in 21% lower Medicaid costs compared with the highest-risk SMI population. Our members complete their education, find paid work, and achieve health and wellness goals at significantly higher rates than people living with SMI who do not have access to similar programs.

In March 2023, the Adams administration pledged $7 million to expand clubhouse capacity in New York City, which will help the city's 16 clubhouses serve more people with SMI and provide stabilizing support before, during, and after mental health crises. But even with this new funding, clubhouses will not have the capacity to serve all of the hundreds of thousands of New Yorkers living with SMI who would benefit from clubhouse membership. Growth in sustained investments to community-based mental health models like clubhouses can and should be an integral part of any government investment in the mental health landscape to meet the health and social needs of people living with SMI.

To increase the number of New Yorkers who can be supported by clubhouses—a proven model that has been linked to fewer hospitalizations and crises for members—we recommend these actions:

- The federal Centers for Medicare and Medicaid Services (CMS) clarifies states' authority to use Medicaid funding for psychosocial rehabilitation (such as the clubhouse model) and encourages states to do so. New York state and New York City should take advantage of this, which would make it much more cost-effective for organizations to operate clubhouses and reach Medicaid-eligible people living with SMI.

- The New York State Department of Health can also authorize Medicaid reimbursement for psychosocial rehabilitation within the state, as other states have done.

- The City of New York should continue to scale up its investment in clubhouses in the coming year to include funding for capital expansions as well as programming to serve more members and provide the types of support that have been linked to reducing mental health crises.

Smoother integration into the social service system.

Fountain House's members said that stressors in their lives—like economic insecurity, housing insecurity, job insecurity, inaccessible health care, family violence, and unsafe shelters—have profound effects on their mental health. Right now, the 988 system is not directly connected to other city-funded services that support New Yorkers facing these stressors. Instead, they need to call one hotline for help with their mental health needs, then must navigate other city systems to address the issues that are causing or exacerbating those needs.

To improve the 988 crisis response system's ability to help New Yorkers address the social and economic stressors that could be causing or exacerbating their mental health crises, we recommend these actions:

- The City of New York should integrate the 988 helpline with other city-funded services, such as 311; the domestic violence hotline operated by Safe Horizon; and housing assistance hotlines operated by the Human Resources Administration.

- When New Yorkers call 988 for help during a mental health crisis, they should be able to receive support and de-escalation over the phone and then, if appropriate, be directly connected to another hotline operator who can address their social and economic needs. The city should be intentional about minimizing bureaucracy as it connects these services so that people experiencing a crisis or profound mental health stress do not experience additional frustration and anxiety.

Increased trust, because the City of New York has welcomed peer oversight of the mental health crisis response system.

As the city implements these foundational changes to crisis response, it will be critical to have ongoing guidance and oversight from New Yorkers experiencing SMI and those who have interacted with the mental health crisis response system.

The City of New York should establish a Peer Oversight Board composed of people living with SMI to offer input and oversight on the 988 system and its implementation. This council should be invited to work with the city to do the following:

- Review and revise the 988 call-taker script to ensure it helps de-escalate crises quickly, clearly communicates that the questions are meant to help support callers' safety and address their needs, and explains the options available to callers.

- Review and revise the 988 call-taker training to develop recommendations for improving and expanding training protocols, including expanding training to support people with mental health needs who are experiencing loneliness or isolation.

- Review and revise 988 mobile crisis team referral protocols and develop success metrics and tracking protocols to allow the city to assess the quality of care the teams deliver.

- Recommend strategies the city must implement to support care navigation through the 988 system.

Step 2: Encourage New Yorkers to reach out to a trusted, well-resourced 988 system for all mental health crises, diverting as many calls as possible from 911 to 988.

Once New York City has taken steps to close trust and service gaps for calls to the 988/NYC Well system, we recommend that it begin a significant and sustained effort to make 988 the default system for addressing mental health crises in the city. This will involve increasing the capacities of call takers, mobile crisis teams, respite care centers, and clubhouses.

Fountain House believes every person experiencing a mental health crisis should have access to a health-led response. We urge the City of New York to accelerate the transition from 911 to 988 in the following ways:

Scale service capacity within the 988 system.

To scale the 988 system's capacity to provide services during all mental health crises in New York City, we recommend these actions:

- **Invest in hiring more 988/NYC Well peer and mental health professionals to ensure that staff will still be able to answer calls in under one minute as the number of calls coming into the 988 system increases.** Adjust funding on an ongoing basis to continue to achieve this goal.

- **Scale mobile crisis team capacity so that these teams are able to arrive within minutes when dispatched as the number of calls coming into the 988 system increases.** Increasing the number of mobile crisis teams will not be possible through additional funding alone. The city is already experiencing a significant shortage of peers, nurses, and social workers, with widespread vacancies for these roles within government, hospitals, clinics, and nonprofit service providers. New York City must invest in workforce pipeline strategies to grow the mental health workforce and explore tactics such as increased compensation, scholarships, and student loan forgiveness to incentivize and retain mental health professionals to fill these positions.

- **As more New Yorkers begin to call 988 instead of 911 during mental health crises**, the city could consider allowing the 988 system to dispatch the B-HEARD teams of paramedics and social workers who currently respond to some nonviolent 911 calls.

- **Continue to scale crisis respite center and clubhouse capacity** and facilitate direct connections between 988, mobile crisis teams, and these community-based care and support services.

Continue to improve trust in the 988 system.

To continue to improve trust in the 988 system as it becomes the default response to mental health crises in New York City, we recommend that the city take these actions:

- **Work with the recommended Peer Oversight Board to establish clear, transparent policies for how the city will respond to mental health crises where there is a suspected risk of imminent violence or the presence of a weapon.** One option may be to have public health responders always be part of the response team and to engage the public safety system as backup only in rare instances.

- **Work with the Peer Oversight Board to establish clear, transparent policies that indicate when mobile crisis teams may seek involuntary hospitalization as a last resort.** These guidelines should ensure that involuntary hospitalizations only occur when necessary to help someone stabilize so that they can regain the ability to make decisions about their own care. Any decisions regarding hospitalization should be made by mental health professionals, not by public safety officers.

Invest in significant 988 public education campaigns.

Both 911 and 988 are "calls for service" systems—when the public calls, extensive state and federal regulations dictate how the city must respond. Reducing use of the 911 system and moving as many mental health crises as possible into the 988 system, then, will require significant, sustained public education to encourage New Yorkers to trust the 988 system and to rely on its ability to provide a response within minutes and deliver helpful, respectful care.

If the city adopts the recommendations in this paper in order to make 988 a trustworthy, well-resourced, responsive system, we recommend that it invest in two public education campaigns:

- One campaign should be designed by and directed toward people with SMI and people who have interacted with the mental health crisis response system to encourage them to reach out to 988 for help during a mental health crisis. This campaign should highlight staffing and capacity changes to assure people that their calls will be answered by peers and professionals

who understand their needs, and that they can request that someone come to them to provide care within minutes. The goal should be to gain the trust of people with SMI, many of whom may be wary of city services because of their past experiences trying to access them. Most importantly, the city should widely advertise these changes and their commitment to upholding them, along with a mechanism to ensure proper treatment and care for those who call.

- The second campaign should encourage all New Yorkers to see mental health crises as a public health issue, not a public safety issue. It should emphasize that the most appropriate response to a mental health crisis is mental health care, and that 988 can deliver such care quickly. The campaign should reduce the stigma surrounding SMI, educate the public about how mental health crises can manifest, and use that education and compassion to advertise 988 as the most effective way to get someone in crisis the help they need.

Conclusion

Laying the foundation for a safer, healthier New York City

If New York City implements the recommendations in this paper, more New Yorkers will have rapid access to appropriate support during a mental health crisis and to stabilizing care that could help prevent future crises. When crises do occur, systems and services will be in place to keep the people experiencing crises, their families, and first responders safe. And the city could noticeably reduce the stigma faced by people living with mental illness.

We urge the City of New York to seize the full potential of federal and state funding and act with urgency to build a mental health crisis response system that truly meets the needs of the hundreds of thousands of New Yorkers who seek crisis mental health care every year.

Appendix

Three ideal 988 user experiences

Below are three possible experiences New Yorkers could have if they reached out to a well-resourced, trusted 988 system for help during a mental health crisis.

USER EXPERIENCE 1: Sam's Mental Health Journey

Sam (not his real name) has been a Fountain House member for 11 years.

Last year, Sam helped create the citywide 988 public awareness campaign that features stories of people living with serious mental illness who have become call takers and now serve their peers. Sam also helped shape the script and training for 988 call takers.

For a couple of weeks, Sam has been hearing more voices.

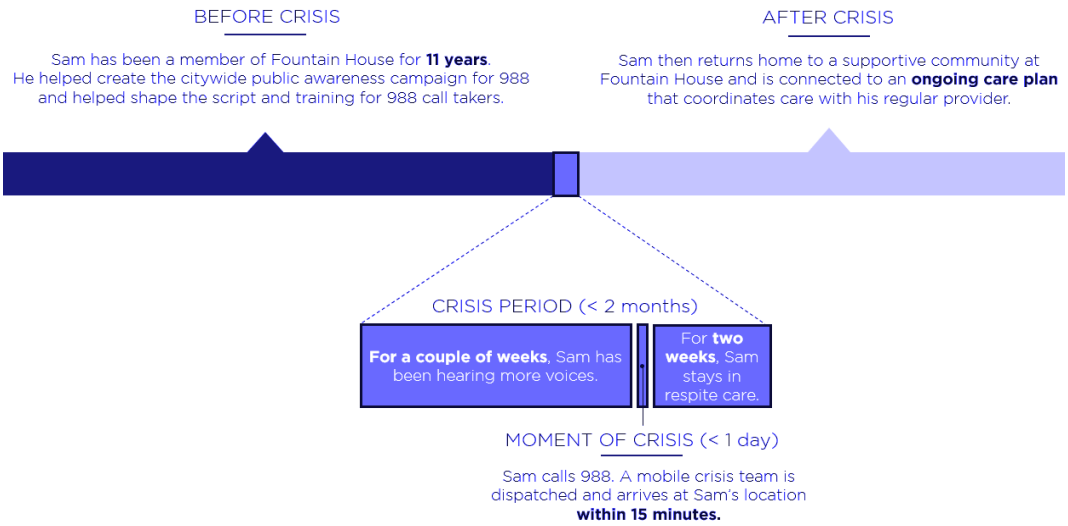
At 2 a.m., the Fountain House clubhouse is closed, so Sam cannot reach his regular provider. He knows and trusts 988. Sam calls 988, and a call taker—a trained peer—answers on the second ring. The call taker asks Sam what is happening and what he needs to feel safe, and explains Sam's options. Together, Sam and the call taker decide it would be helpful to have a medical team come to Sam's home.

A mobile crisis team including a social worker, nurse, and peer arrives at Sam's home within 15 minutes. They calmly introduce themselves, ask Sam what would make him feel comfortable (maybe food or water, for example), and explain the kinds of care they can provide. Sam tells them what tests and onsite care would be helpful to him, and he receives the care he requests. He and the mobile team decide together that a stay in respite would benefit him, and the team facilitates immediate enrollment in and transport to a respite care facility.

Sam is quickly admitted, and he stays for two weeks. The care team at the respite center adjusts his medication and ongoing care plan in coordination with Sam and his regular provider. Sam receives supportive cards from his community at Fountain House while staying at the respite center.

Sam returns home.

Sam's Timeline



USER EXPERIENCE 2: Laila's Mental Health Journey

Laila (not her real name) has just graduated from high school, and she is living on her own for the first time. She has never sought mental health care before.

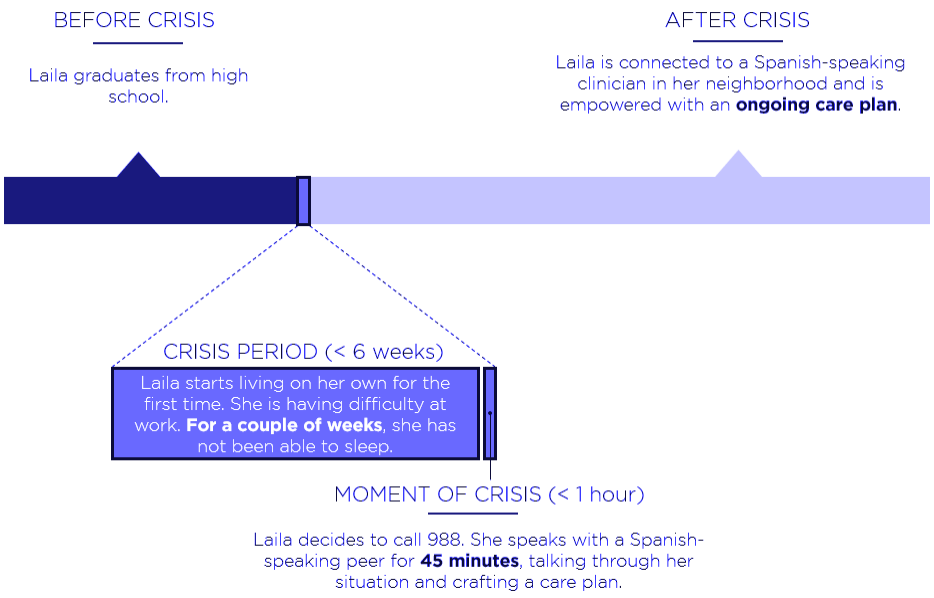
Life is getting stressful. Laila is having difficulty with a supervisor at work who has started harassing her. She is worried about losing her job and what that would mean for her—she would not have enough money for rent and she would lose her health insurance. Her anxiety has affected her sleep for a couple of weeks.

Laila has seen a poster about 988 and noted that the helpline offers free 24/7 support from native Spanish speakers. Because Spanish is her first language, this gives her some comfort; she feels that the call takers might understand her and her culture.

Laila decides to call 988. A trained peer answers within seconds and asks Laila how they can help. Laila says she would feel more comfortable speaking in Spanish, and the call taker immediately transfers her to a peer who is a native Spanish speaker. Laila explains the stress she has been feeling. The peer stays on the phone with Laila for 45 minutes, talking through her situation, her feelings, and her needs.

Laila and the call taker decide on a plan: The peer call taker makes an appointment for Laila at a Health + Hospitals clinic in her neighborhood with a Spanish-speaking therapist who can provide care and help her identify and enroll in an alternative insurance plan. The call taker then connects Laila to the state's hotline that provides free support for people experiencing harassment in the workplace.

Laila's Timeline



USER EXPERIENCE 3: AJ's Mental Health Journey

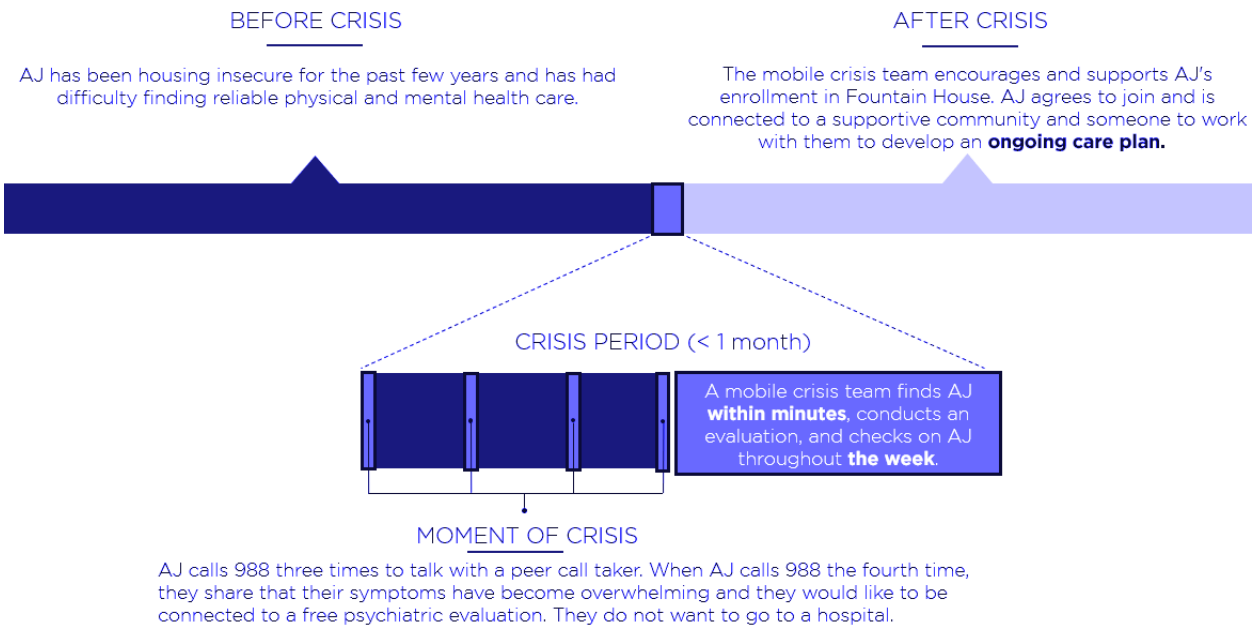
AJ (not their real name) learned about 988 from the Recharge Station, a kiosk operated by Fountain House in Times Square that offers free water, coffee, phone charging, blankets, and connections to mental health and housing resources. AJ has been housing insecure for the past few years and has had difficulty finding reliable physical and mental health care.

AJ is drawn to 988's offer of free 24/7 support. They call a few times to speak with a peer anonymously from a private location. The peer call takers stay on the phone with AJ for 30 minutes and share stories about their own experiences with mental health care and with Fountain House. Each time, the peer call takers communicate that when AJ feels ready and comfortable, they would be happy to connect AJ to the kind of support AJ wants.

The fourth time AJ calls, they share that their symptoms have become overwhelming and that they would like help getting a psychiatric evaluation, but they are worried about going to the hospital. The peer call taker offers to send a mobile crisis team operated by the city to AJ's location to perform an evaluation. AJ agrees and shares their location.

The mobile crisis team arrives within a few minutes and provides AJ with care, including a psychiatric evaluation. AJ and the mobile crisis team work together to develop an after-care plan that includes the mobile crisis team coming back to check up on AJ every other day for the next week. The team offers to drive AJ to the nearest clubhouse and support AJ's enrollment in the clubhouse's community. AJ agrees.

AJ's Timeline



Testimony to the City Council Committee on Mental Health, Addiction, and Disabilities

May 4, 2023

Dear Chair Lee and Committee Members,

Thank you for this opportunity to testify on the Council's Mental Health Road Map. I am the Co-Director of Freedom Agenda, a member-led project dedicated to organizing people and communities directly impacted by incarceration to achieve decarceration and system transformation. We also coordinate the Campaign to Close Rikers. Our members have lived and are living through the painful impacts of divestment from our public health infrastructure, and reliance on law enforcement to fill the gap. They know firsthand that jail is the most expensive and least effective response our City has to the mental health crisis we are collectively experiencing.

We are grateful for the leadership the Council has taken – in this Road Map, and in your budget response – to address the urgent issue of adequately resourcing our mental health infrastructure. For so many years, we have existed in a shameful status quo in which everyone agrees that people with mental health needs should not be in jails and cannot have their needs met there, but everyone in power continues to allow it to happen.

We have seen the dire consequences of the status quo. Since Mayor Adams and this Council took office, the number of people in our jails who are diagnosed with serious mental illness has increased by 38% percent. Board of Correction reports indicated that at least 10 of the people who died in DOC custody last year had mental health diagnoses. We can expect this shameful pattern to continue if we don't make a substantial change. But our city has successes to build upon, and hopefully the political will within our city council to fund those models to scale, and fully support their implementation.

We strongly support many of the proposals within the Road Map, and the full range of approaches is badly needed – from community-based care to off-ramps from the jail system, and efforts to build the workforce necessary to facilitate this transition.

Specifically, we stand in strong support of:

- Increased funding for IMT, ACT, and FACT teams
- Intro 1021-2023, expanding the number of crisis respite centers
- Increased funding for and restructuring of the 15/15 supportive housing program, and increasing production of and funding for supportive housing through state action as well
- Intro 1022-2023 expanding the presence of clubhouses in highest need areas
- Reso 0156-2022 in support of the Treatment Not Jail legislation at the state level
- Funding for school-based and shelter-based mental health services and the Mental Health Continuum
- Addressing the mental health workforce shortage through a CUNY social work fellows program, and better compensation for the public health, non-profit, and human services workforce

- Resolutions 0583-2023, 0584-2023, and 0587-2023 calling for state action to address the mental health workforce shortage

We particularly want to emphasize our support for the Council's commitment to increased funding for the Justice Involved Supportive Housing program (JISH), designed to meet the needs of New Yorkers who most frequently cycle between jails, shelters, and hospitals. As the Road Map notes, the Close Rikers agreement included a commitment to creating 380 more JISH units. More than three years later, those units still do not exist, because the City has been unwilling to allocate sufficient funding to attract qualified providers. Supportive housing providers have been asking since Fall 2021 for the services rates, currently at 10K, to match those for the 15/15 young adult population ($25,596K). It is unconscionable for the administration to be questioning the feasibility of reducing the jail population and closing Rikers when they have not implemented a basic part of the plan that would cost only $12.8 million. To put this context, DOC spent $21 million in overtime in the month of March.

We'd also like to highlight one key issue that we see missing from the Council's Road Map. NYC's largest supportive housing program, NYC 15/15, is designed to serve those who are homeless, and its ability to scale and succeed is incredibly important to many clients who are also receiving services overseen by DOHMH. **Experts are asking that NYC 15/15's eligibility criteria be expanded to allow incarceration time to be counted as time homeless, and the Council should introduce and pass legislation to do so.** Currently if a person who is homeless is incarcerated at Rikers or elsewhere and held longer than 90 days, they are no longer eligible for 15/15. This sends people leaving incarceration to the end of the waitlisting list time and again. Part of what has made JISH so important is that it's eligibility rules are designed to quickly serve people who have been in jail more than 90 days, and 15/15 should be able to serve the housing needs of these New Yorkers too.

Finally, I want to state our support for the Council's plans to address the mental health workforce shortage. Not only is this critical to implementing so many aspects of this Road Map, it's also an important step toward an overdue workforce transition for our city. We are closing Rikers Island, and that will mean less jobs in the Department of Correction. From the mid-nineties to now, NYC's jail population has declined by nearly 75%, but the number of correction officers hasn't. We now have four times more officers per incarcerated person than the national average. Instead of putting off the work of rightsizing DOC, our City should be proactively embracing this transition. Instead of relying on DOC as a jobs program Black and Brown New Yorkers without advances degrees, including many women, we should be creating accessible pathways into the public health jobs our city needs, and fighting to ensure these jobs are well-compensated.

In summary, I want to thank the Council for your leadership, and offer our partnership in moving this plan forward.

Sincerely,

Sarita Daftary

Co-Director, Freedom Agenda

Sdaftary@urbanjustice.org

NYC Council Committee on Mental Health, Disabilities, and Addiction

May 4th, 2023 -- Hearing on the NYC Council's proposed Mental Health Roadmap

Good morning, Chairwoman Linda Lee and members of the NYC Council Committee on Mental Health, Disabilities, and Addiction. My name is Lilya Berns, and I am submitting written testimony regarding the NYC Council's Mental Health Roadmap on behalf of Hamilton-Madison House (HMH) as its Assistant Executive Director of Behavioral Health Services.

Hamilton-Madison House is the second-largest behavioral health clinic that serves Asian-Americans in the United States and the largest outside of Los Angeles, serving more than 600 clients annually. We provide culturally- and linguistically-competent psychiatric services, individual, family and group therapy in 7 languages for Chinese, Japanese, Korean and Southeast Asian clients, PROS (Personalized Recovery Oriented Services), Asian American Recovery Services (for substance use disorder), and a Supported Housing program. Our Article 31 behavioral health clinic has operated in partnership with the NY State Office of Mental Health since 1974, and our Article 32 Asian-American Recovery Services has operated since 1983.

Hamilton-Madison House has reviewed the NYC Council's Mental Health Roadmap, and we write in overall support of the many initiatives therein.

Today we would especially like to bring to this committee's attention the following topics germane to our practice:

1. The need to fund the **CONNECT demonstration program** past 2024.
2. Expand the Roadmap's **workforce development initiatives** to **internships** and **fellowships** that are long-established, and have been serving as the pipeline for the diverse, culturally-sensitive and linguistically-competent mental health workforce our City needs
3. **Fair Medicaid reimbursement** for all services, including non-billable case management and services for uninsured and undocumented individuals
4. Consistent funding of **culturally-sensitive and linguistically-competent psychosocial clubhouse-style community centers** for the AAPI community and sustain them as compared to past efforts
5. Mapping and data on outpatient mental health providers in our communities
6. Expand **Supportive Housing Initiatives** to increase permanent housing & wraparound services for severely mentally ill individuals

1. The CONNECT Program: DOHMH "Continuous Engagement between Community and Clinic Treatment"

HMH supports the Roadmap's provisions on the expansion of funding for teams that bring treatment directly into our community, including the DOHMH Intensive Mobile Treatment Teams, the Assertive Community Treatment Teams (ACT teams), and the Forensic Assertive Community Treatment Teams (FACT teams).

However, we strongly implore this Committee, when funding these outreach teams, to **NOT OVERLOOK DOHMH's CONNECT program:** the "Continuous Engagement between Community and Clinic Treatment."

Launched in May 2022 in collaboration with DOHMH and the Mayor's Office of Community Mental Health, the CONNECT program extends the clinic into the community, provides an extra layer of mental health support, and helps clients gain rapid access to case management and clinical services. CONNECT is currently being piloted at nine clinics in high-need areas throughout the Bronx, Manhattan, and Brooklyn, with a target of serving up to 900 clients per year.

For HMH, the CONNECT program has been invaluable in extending our robust behavioral health services into our community and allowing us to reach more of our neighbors struggling with mental illness. Particularly for the seniors who have struggled with social isolation and fear of anti-Asian harassment and assaults, the ability of the CONNECT clinical team to meet them at their home or wherever they are most comfortable, is life-changing. CONNECT's "treatment without walls" outreach model synergizes well with our long-standing behavioral health clinic that has been serving the community since 1974. HMH wants to build on the successes of our program and **asks the Council in its Roadmap to sustain this impactful initiative past its current end date of Dec 31, 2024**.

The CONNECT program is a form of community-based treatment in many ways similar to an ACT team, in that we can go into the community – whether at local parks, shelters, soup kitchens or to the homebound -- to administer treatment such as psychiatric assessment, counseling, long-acting psychiatric injections, and address immediate needs such as food, shelter and all aspects of case management. Therefore, the CONNECT program may be seen as a form of "ACT-lite" that intervenes earlier, preventing further deterioration of a client suffering with mental illness and helping us break the cycle of hospital re-admissions and discharges. CONNECT fills a critical gap in the continuum of treatment within our mental health treatment ecosystem – between the clinical level of care and the assertive outreach teams: IMT/ACT/FACT. ACT teams are evidence-based treatment for our seriously mentally ill neighbors. CONNECT, which intervenes earlier, and with less onerous admittance requirements, is trending and will prove to be just as effective in the future.

We also provide ACT step-down services to allow clients a more gradual transitioning process from ACT-level to outpatient-level services, so they do not get lost in the shuffle of suddenly managing their own appointment schedule or attending appointments onsite. Additionally, we also take in clients who are on the SPOA waitlist for an ACT/FACT/IMT team.

To fill the mental health services gap and reduce recidivism, CONNECT also prioritizes those who have been recently released from correctional facilities and ACT step-downs in our catchment area of the Lower East Side.

2. <u>Workforce Development – Interns and Fellows</u>

HMH supports the provisions regarding workforce development in the Roadmap, particularly the first point on "adequate funding allocations to nonprofit and community-based organizations, with a focus on organizations that provide culturally competent and linguistically diverse mental health supports and services" as our lived experience shows that funding hitherto has been inadequate.

For decades, we have developed, on our own, a talent pipeline of culturally competent and linguistically-diverse Asian-American mental health professionals, who provide the necessary language ability, mostly at our own expense. Many of those capable staff are international students who first interned with us and then remained as permanent staff. In order to stay beyond their internship year, they must be

sponsored for a work visa, H1B or green card. Though our diverse clinicians currently deliver behavioral health services in 7 languages and 7 dialects, in the past that number has been as high as 10 languages and 16 dialects. Over our storied history, we've had sporadic, piecemeal financial support from our City and State funding partners for our talent sustainability efforts. In the last few years, we have sponsored 36 H1-B work visas and 7 Green Cards. Each H1-B sponsorship costs HMH $3,500; each Green Card $8,000. Of these, only 9 of those sponsored H1-B clinicians are still on staff, and 3 of those sponsored Green Card clinicians remain on staff. Despite the substantial costs of sponsorships and efforts to maintain a competitive compensation package to retain talent, our organization has not been able to compete with larger, for-profit systems, ultimately where those staff ventured to. This is a tragedy reflecting the staffing retention crisis that has deeply impacted nonprofit organizations like ours amid an already dangerous shortage of human service workers. To serve the ever growing Asian-American population and fulfill the critical, ongoing need for cultural- and language-sensitive clinicians, we must continue to recruit interns who are international students and provide work sponsorships.

As part of the workforce development pillar of the Roadmap, HMH calls for City support for talent development programs like ours. We've already been doing this hard work for years on our own, out of the necessity to provide for the culturally sensitive mental health needs of our community and because of that, we are on the brink of financial collapse.

We need unrestricted financial assistance to sustain our Master's- and pre-doctoral interns, and post-Doctoral fellows, which will not only allow us to increase the number of interns/fellows we can train, but it will also allow us to increase the number of clients we can serve.

Mental health providers within our diverse communities need to be prioritized, doing so will require ongoing financial commitment, equitable reimbursement, and competitive compensation to attract and retain the bilingual providers that are desperately needed to treat the mental health crisis within our community.

3. <u>Fair Medicaid Reimbursement</u>

HMH supports Councilmember Lynn Schulman's Res. 592-2023, calling for an increase in the Medicaid reimbursement rates for behavioral health services.

Article 31 community-based behavioral health clinics across NY State are either closing their doors or are merging with Federally Qualified Health Centers due to grossly inadequate Medicaid reimbursement rates measured against the rising costs of operating a clinic. Mission-driven nonprofits like ours have put up with this unfair financial disparity and "done more with less" for the sake of serving the community, but the ongoing fiscal neglect is reaching a breaking point.

In Fiscal Year 2021 (July 1, 2020 through June 30, 2021), the payer mix for HMH's Behavioral Health Services patients included: 54% Medicaid Managed Care/Fee-for- Service; 27% Medicare; 13% Commercially Insured; and 6% Uninsured. These figures are consistent year-to-year.

These rates are not conducive to our agency's sustainability.

In addition, we ask this Committee to consider a mechanism for the reimbursement of services that clinics like ours render, for free and at our own expense, in order to serve individuals who are uninsured or undocumented with the same level of compassion and cultural- and language-proficiency. We serve

as a safety net for individuals who cannot afford the critical help that they need. Even large hospital systems rely on us to bridge the gap for linguistic and culturally competent care.

4. Psychosocial Clubhouses

HMH supports Councilmember Kevin Riley's Int. No 1022-2023 to establish "clubhouse" -style psychosocial community centers for individuals with serious mental illness in high-need areas.

HMH piloted a clubhouse-style center 2002-2009 alongside our supportive housing and our Korean Clinic located in Corona, Queens. We believe our clubhouse was the first of its kind to specialize in Asian-Americans with serious mental illness; we estimate we saw 30 clients annually at this location. However, due to a lack of consistent financial support from the City and State at that time, we were forced to shutter the clubhouse, cutting off the Asian-American community from what could have been a crucial community center and resource. Therefore, we heartily welcome this initiative in the Mental Health Roadmap and we stand ready to work with our City and State partners to re-open a psychosocial clubhouse in a high-need neighborhood that utilizes our strengths in serving the Asian-American community.

5. Data and Mapping

HMH supports Int. 1019-2023, sponsored by Chairwoman Linda Lee, providing for the development of a user-friendly searchable database and map of outpatient mental health providers in NYC.

6. Supportive Housing

HMH supports Res. 588-2023, sponsored by Majority Leader Keith Powers, calling for a reinstatement of City and State Supportive Housing Programs.

We currently house 50 clients in our supportive housing co-located with the Korean outpatient behavioral health clinic in Corona, Queens. Historically, we have housed more than 50 clients, and we would have the capacity to take on more, if we had more funding. 50 supportive housing beds is not nearly enough to address the housing needs of the Asian-American community living with serious and persistent mental illness, needing around the clock case management. Asian-Americans are 18% of the population of NYC, (or one-in-six New Yorkers) and remain the fastest-growing community in the City.

Concluding Statement

To summarize, we ask the Committee to:

- Commit to continuous funding of the CONNECT program
- Fund existing internship programs focusing on culturally sensitive, linguistically competent mental health professionals to develop a multilingual City talent pool
- Increase Medicaid reimbursement for behavioral health services
- Establish psychosocial clubhouses in high-need areas
- Re-establish the City/State supportive housing program

Now more than ever, our community needs mental health support that is culturally-sensitive and linguistically-competent. Hamilton-Madison House provides that, even though our clients are often

unable to afford that care, because we do not leave anyone behind. The demand for mental health services among the Asian-American community is at the highest it's ever been, partly due to anti-Asian hate crimes and isolation associated with the COVID-19 pandemic. The one positive from recent years is the slow breakdown of the stigma associated with seeking mental healthcare. As such, we are running into the limitations of service capacity of affordable, culturally- and linguistically-accessible mental health services for our community. Demand is latent, but low supply constricts service distribution.

Thank you for your time, your attention and your thoughtful consideration of this testimony.

New York City Council Committee on Mental Health, Disabilities & Addiction

TOPIC: Mental Health Roadmap Legislative Package

Thursday, May 4, 2023

Testimony by

Wendy Perlmutter Finkel

Director of Government Relations

Good morning Chair Lee and members of the Committee. Thank you for allowing me to testify on behalf of JCCA and the youth and families we serve. I am here to thank you and your many staff members for constructing the ambitious mental health plan that is desperately needed by so many in New York City today.

My name is Wendy Perlmutter Finkel, and I am the Director of Government Relations at JCCA. I have worked in roles at the intersection of child welfare and mental health for 15 years, and I am proud to represent JCCA at today's hearing.

JCCA is a 200 year old organization that works with about 17,000 of New York State's children and families each year, providing mental and behavioral health services, foster and residential care, prevention, and educational assistance.

In particular, our Behavioral Health and Wellness division provides critical support to youth throughout New York City and Westchester with serious behavioral and mental health challenges who have experienced trauma, including child sexual abuse and commercial sexual exploitation. Our goal is to decrease traumatic hospitalizations and to provide youth with resources to stay in their communities and with their families, so that they can minimize their odds of needing intensive services when they grow into independent adults. Our programs include:

- Health Homes, a program that provides case management and community referrals for youth with chronic medical and mental health conditions and/or complex trauma;
- Community and Family Treatment Support Services, our suite of psychiatric supports, family and peer counseling, and psychosocial rehabilitation services provided right in a family's home or community setting;
- Home and Community Based Services, providing family advocacy and respite for young people with complex medical and/or psychiatric diagnoses;
- Center for Healing, which provides evidence-based and trauma-informed treatment for youth who have experienced sexual abuse or commercial sexual exploitation;
- Psychology Services, the JCCA department that provides assessment and evidence-based treatment to children in our foster and residential programs; and
- The Brooklyn Child and Adolescent Guidance Center, our Article 31 Clinic, which provides psychiatric evaluations, therapy, and medication management.

We aim to provide a continuum of care, from comparatively light-touch services to the more intensive and integrated care necessary for youth with the most acute and complex needs.

The Council's Mental Health Roadmap makes great strides in filling gaps in New York City's continuum of care to meet the range of needs of New Yorkers. We applaud the City Council's recognition that New Yorkers need both crisis services and on-going care located in their immediate community and without the long waitlists that are prevalent through the city. As a provider of children's mental health services, we are pleased to see the commitment to expand school-based mental health services. We know firsthand from our own relationship with Coney Island's Liberation Diploma Plus High School, how valuable it is to provide clinical mental health services that are easily accessible to students. The school principal has long asked JCCA to open a satellite of our Article 31 clinic in the school, and we are thrilled to begin providing these services.

We are thrilled that the Council recognizes of the need for varied and robust services in young people's communities. We appreciate telehealth, but for children in particular, home-based and local neighborhood options that allow for in-person connections are invaluable. Intensive community-based services can help. Last year, in collaboration with the NYS Office of Mental Health, JCCA became the first Youth ACT provider in New York City. Our Youth ACT team meets the acute mental health crisis among young people, serving those with Serious Emotional Disturbance who are at risk of, or have recently returned from, psychiatric hospitalizations. We have made great strides with our caseload, but we serve a fraction of the young people who would benefit from such services. We respectfully ask that you continue the fight to support mental health programs for young people.

Finally, thank you for including specific actions to address the mental health workforce shortage. Programs are poorly funded; reimbursement rates are barely enough to cover the direct care, let alone infrastructure, and support staff. The Mental Health Roadmap's commitment to advocate for additional budget funding allocations for culturally competent and linguistically diverse

mental health supports and services, as well as the fund for a Social Work Fellows Program, would go a long way in helping agencies such as JCCA maintain the workforce needed to meet the significant demand for mental health services.

Conclusion

We greatly appreciate the opportunity to testify at this hearing and look forward to collaborating to help New York City's children and families access mental health services.

New York City Council Hearing on the Mental Health Roadmap Legislative Package

before the

Committee on Mental Health, Disabilities and Addiction

on

Thursday, May 4th, 2023 at 10:00am

Oral Testimony By: Caitlin Garbo, MPA
Manager of Public Policy & Advocacy
National Alliance on Mental Illness of New York City (NAMI-NYC)

Good afternoon Chair Lee and Members of the Committee on Mental Health, Disabilities and Addiction. My name is Caitlin Garbo. Today, I am here on behalf of the National Alliance on Mental Illness of New York City, NAMI-NYC, which is the *only* nonprofit providing direct and extensive family support to New Yorkers who care for someone living with serious mental illness. Our renowned peer- and evidence-based services are unique in that they are led both for and by individuals and families affected by mental illness and are reflective of the diversity of New York City and are all available completely free-of-charge.

NAMI-NYC is grateful to see landmark commitments made in the recently announced Mental Health Roadmap. There is so much in there and we are supportive of the legislative proposals that have been put forth. In particular, one component that we are thrilled to see mentioned in this document is **the need to invest in family support services!**

Families are the thread across a fractured system and the first line of care for New Yorkers with SMI, such as major depression, bipolar disorder, and schizophrenia. Families and those close to a person are the first to notice changes in their loved one's behaviors and mood. They are the people who are often there before, during, and after mental health crises or episodes. Some City Council Members may even identify with being a family member in this capacity. When given proper tools and adequate support, *families* can intervene and improve mental health outcomes for peers.

Academic research of family interventions broadly,[1,2] and of NAMI's evidence-based programs specifically,[3] support these claims and all point to the same results: **when a family**

---

[1] Zagorski, N. (23 May 2022). *Family Interventions Benefit People with Schizophrenia.* Psychiatric News. Family Interventions Benefit People With Schizophrenia | Psychiatric News (psychiatryonline.org).

[2] Biegel, D. (11 July 2013). *Family Social Networks and Recovery from Severe Mental Illness of Clubhouse Members.* Journal of Family Social Work. Family Social Networks and Recovery From Severe Mental Illness of Clubhouse Members: Journal of Family Social Work: Vol 16, No 4 (tandfonline.com).

[3] Toohey, M.J. et al. (2016 Feb.) Caregiver Positive and Negative Appraisals: Effects of the National Alliance on Mental Illness Family-to-Family Intervention. J Nervous Ment Dis. 204(2): 156-9. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4734139/.

member is involved, emergency room visits and psychiatric hospitalizations decrease, and there is greater engagement with community-based mental health care.[4] To reiterate, NAMI-NYC is the *only* nonprofit offering these direct and extensive supports to family members in New York City involved in the life of someone living with SMI. **For this reason, our organization is asking the city to make a $250,000 investment in our one-of-a-kind, evidence-based family support programs, which are critical to helping New Yorkers affected by mental illness**. With this funding, NAMI-NYC will be able to expand our free mental health Helpline, evidence-based education classes, nearly 40 monthly support groups, and Family Match mentoring program to underserved communities throughout all of New York City. This modest funding ask will also remove the burden from city agencies to implement new programs with the same end-goal as the programs NAMI-NYC has already provided for over four decades.

None of us is born knowing how to support, understand, and connect with someone living with SMI. Fortunately, NAMI-NYC equips families with knowledge, skills, and ongoing support to better identify symptoms, improve access to care, enhance communication with their loved one, and heal family relationships. And with this modest funding request, we can bring family support to even more New Yorkers, especially in underserved communities, absolutely free regardless of income, insurance, or immigration status.

Thank you for your consideration and we look forward to continue working together towards solutions in our mental health care continuum. And happy mental health awareness month!

---

[4] *Id.*

NCSBN
Leading Regulatory Excellence

111 E. Wacker Drive, Suite 2900 · Chicago, IL 60601-4277

Committee on Mental Health, Disabilities and Addiction
The New York City Council
City Hall Park, New York, NY, 10007

May 2, 2023

Dear Council Members,

On behalf of the National Council of State Boards of Nursing (NCSBN)[1], I am writing to express our support for Resolution No. 584, which implores the New York State Legislature to increase the portability of mental health providers by enacting several licensure compacts, including the Nurse Licensure Compact (NLC). Thank you for holding a hearing on this important issue.

One in five New Yorkers experience mental illness each year, however, access to care is disproportionately available across New York City[2]. To further exacerbate problems associated with unequal access, workforce shortages are prevalent with mental health care programs in New York experiencing staffing vacancy rates of 30-40%[3]. Workforce shortages are a foundational issue to expanding the availability of mental health care[4] Increased licensure portability is one strategy to address workforce shortages, enabling providers to easily provide care to patients, thereby increasing access to care.

Modern health care delivery requires that nursing care, today and in the future, be seamless across state lines, both for in-person and telehealth nursing care delivery. Increased access to telehealth care delivery models provides continuity of care, enabling patients to see their providers no matter where they are located. The 100-year-old model of nurse licensure in New York is not flexible enough to best meet this need.

The NLC, which has been successfully operational for more than 20 years, allows a registered nurse (RN) and licensed professional/ vocational nurse (LPN / VN) to hold one multistate license, with the privilege to practice in their home state and other NLC states, without obtaining additional licenses. The NLC is currently enacted in 40 U.S. jurisdictions including neighboring New Jersey, Pennsylvania, and Vermont. The NLC is a key element to grow the healthcare workforce as it would attract workers at a time of great need by allowing nurses to easily relocate to and practice in New York, either in person or via telehealth[5].

[1] NCSBN is an independent, not-for-profit organization representing boards of nursing from each state and territory of the United States, including New York.
[2] "Mental Health Dashboard," *Mayor's Office of Community Mental Health*, https://thrivenyc.cityofnewyork.us/dashboard/
[3] New York's mental health care system faces 'workforce crisis,' *New York State of Politics,* https://nystateofpolitics.com/state-of-politics/new-york/politics/2022/02/15/new-york-s-mental-health-care-system-faces--workforce-crisis-
[4] "Availability and Accessibility of Mental Health Services in New York City," *Rand Corporation,* https://mentalhealth.cityofnewyork.us/wp-content/uploads/2023/01/RAND_RRA1597-1.pdf
[5] "Governor Hochul Announces Direct Payments to Healthcare Workers as Part of $10 Billion Healthcare Plan," https://www.governor.ny.gov/news/governor-hochul-announces-direct-payments-healthcare-workers-part-10-billion-healthcare-plan

312.525.3600
ncsbn.org

NCSBN
Leading Regulatory Excellence

111 E. Wacker Drive, Suite 2900 · Chicago, IL 60601-4277

Nurses are important members of interdisciplinary mental health care teams. Nurses with a specialization in psychiatric-mental health care for the needs of individuals, families, and communities through identification, treatment, and prevention[6]. Nurses are crucial in helping individuals manage their symptoms, establish coping skills, and mitigate further disability from mental health issues[6].

While nurses are an integral part of the mental health care team, access to nurses in New York is in a state of crisis with a projected shortage of 39,000 nurses by 2030[7]. The negative impacts of this shortage were encapsulated in the recent strike by Mount Sinai Health System and Montefiore Health System. Nurses went on strike in response to increased burnout due to chronic understaffing, which negatively impacts the ability of nurses to maintain high levels of patient safety[8]. This burnout is not unique to New York but is heavily impacting the supply of nurses nationwide, and the mental health of nurses themselves. Across the country, 100,000 RNs left the workforce due to the stress of the COVID-19 pandemic and over 800,000 RNs expressing an intent to leave the workforce by 2027 due to burnout, stress, and retirement[8]. To effectively combat these pervasive workforce challenges, it is imperative that New York take advantage of every tool available to supplement the nursing workforce.

The NLC is an efficient solution to maintain a nursing workforce pipeline and implement a permanent solution for licensure mobility for nurses across the state and country. This is especially imperative to aid in New York's efficient response to the mental health staffing shortage. The NLC will ensure New York can call on a safe and vetted group of high-quality nurses to fill current gaps in care for residents both in person and via telehealth, incentivize nurses to relocate New York where they have greater employment opportunities with a mobile license and access to mental health services, and increase opportunities for current New York nurses to join a modern and mobile workforce.

NCSBN thanks you for your dedication to addressing the New York mental health provider shortage and recognition of the NLC as a valuable tool in the toolbox to aid in combating this ongoing crisis.

Respectfully,

Nicole Livanos, JD, MPP
Director, State Affairs, NCSBN
nlivanos@ncsbn.org

[6] "Psych Nurse FAQs," *American Psychiatric Nurses Association*, https://www.apna.org/psych-nurse-faqs/
[7] "Study of Nurse Caregiver Minimum Staffing Levels and Other Staffing Enhancement Strategies and Patient Quality Improvement Initiatives," *New York State Department of Health*
[8] "About 100,000 nurses left the workforce due to pandemic-related burnout and stress, survey finds," *CNN Health,* https://edition.cnn.com/2023/04/13/health/nurse-burnout-post-pandemic/index.html

THE NEW YORK FOUNDLING

590 Avenue of the Americas
New York, New York 10011
212-633-9300
www.nyfoundling.org

Testimony of Melanie Hartzog
President and CEO of The New York Foundling

To the New York City Council Committee on Mental Health, Disabilities, & Addiction
Legislative Hearing on Thursday, May 4th, 2023

As President and CEO of The New York Foundling, one of New York City's largest and longest-serving nonprofit providers of human services, I am pleased to partner with City leaders to strengthen our community's response to the mental health crisis that has impacted so many of our neighbors. Thank you Chair Lee for holding this hearing and giving us the opportunity to provide testimony. We are grateful for the care and attention that the Council has given to this issue in the creation of its Mental Health Roadmap, and importantly, inviting partners to the table to inform its creation. Addressing the complex needs of our community will require the expertise of a broad range of people—from frontline workers to researchers, data scientists, policymakers at every level, and most importantly, community members who rely on these services to meet their basic needs.

We applaud the Council's steadfast dedication to creating meaningful change at the systemic level. The Council's advocacy to State and Federal actors touches on some of the most important issues shaping the service landscape, and, if heeded, have the potential to drive large-scale impact. For example, the rate increases advocated in Resolution 0592 have the potential to narrow the gap between the true cost of high-quality service provision and the amount that is currently reimbursed by Medicaid—one of the biggest obstacles to achieving the results promised by providing evidence-based treatment using proven models. Additionally, the interstate licensing bill advocated in Resolution 0584 will facilitate hiring and make it easier for families in the tri-state area to maintain continuity of care during times when families need to move around our region.

We are pleased that Council Members Lee, Powers, Rivera, Bottcher, and Riley have introduced Introduction 1019, with the goal of strengthening the accessibility of information for New Yorkers seeking care. This law would require that the Department of Health and Mental Hygiene (DOHMH) develop and maintain a searchable electronic database and map of outpatient mental health provider availability. The new database has the potential to bring together data from providers, the State Office of Mental Health, insurance plans, and existing databases to create a true "one-stop shop" for families seeking much-needed help.

Once again, we are grateful that the Council is taking meaningful steps to address the national emergency in child and adolescent mental health. The actions outlined in the Mental Health Roadmap are important and necessary assessment and crisis response measures. We hope that the Council takes a closer look at the full spectrum of mental health care that includes providers like The Foundling, who provide a vast array of services that go beyond assessment and crisis response. The high-quality evidence-based models that The Foundling specializes in will be critical to preventing crises at every level. With full funding for mental health care and crisis prevention, The Foundling and others like us can address the urgent needs of children and families impacted by the mental health crisis and strengthen our community in the long term—increasing access to

THE NEW YORK FOUNDLING

590 Avenue of the Americas
New York, New York 10011
212-633-9300
www.nyfoundling.org

services that have been proven to prevent homelessness, joblessness, substance use, and crime well into adulthood.

We look forward to working with City leaders to address the mental health crisis and ensure that everyone who needs can access mental health care in New York City. Thank you for your time.

New York Lawyers for the Public Interest, Inc.
151 W. 30th St.
11th Floor
New York, NY 10001-4017
Tel 212-244-4664
Fax 212-244-4570
TTY 212-244-3692
www.nylpi.org

Testimony of

Ruth Lowenkron, Esq., Disability Justice Director

on behalf of

New York Lawyers for the Public Interest

before

The Council of the City of New York

Committee on Mental Health, Disabilities, and Addiction

May 4, 2023

Good morning. My name is Ruth Lowenkron and I am the Director of the Disability Justice Program at New York Lawyers for the Public Interest (NYLPI). I am also a steering committee member of Correct Crisis Intervention Today – NYC (CCIT-NYC), a coalition of over 80 New York City Organizations committed to transforming the way New York City responds to individuals experiencing mental health crises. NYLPI appreciates the vast majority of the Committee's proposed "Mental Health Roadmap" and shares below minor comments regarding the bills and resolutions we support, and details about the one bill we believe is premature and the one resolution which we oppose. We focus our comments, however, on what is

missing from the Roadmap – a failure to address the critical need to transform New York's mental health crisis response and to cease funding the Behavioral Health Emergency Assistance Response Division (B-HEARD) pilot program in its current guise as it is a deeply flawed, as well as a failure to overturn the dangerous and illegal Involuntary Removal Plan announced by Mayor Adams in November 2022 permitting the involuntary removal of individuals who are merely perceived to have a mental illness diagnoses for psychiatric evaluation.

We also take the liberty of including below, at p. 25, another mental health roadmap/action plan that was prepared by mental health advocates in 2021 and would be an excellent supplement to the Council's Roadmap.

THE CITY MUST REVAMP THE B-HEARD PILOT AS THE PILOT AUTHORIZES EXTENSIVE POLICE INVOLVEMENT AND IS LIKELY TO CONTINUE OR EVEN INCREASE THE RATE OF VIOLENT RESPONSES BY THE NYPD

The Council needs simply to look at B-HEARD's own statistics to note that, while it purports to move the City away from responding to people experiencing mental health crises as a threat to public safety, it in fact is part of the long tradition of policing, criminalizing, and under- and mis-serving people with mental disabilities.

Funding B-HEARD in its current iteration diverts money from what we need – a true non-police response system that offers voluntary healthcare, including teams

of peers (those with lived mental health experience) 24/7 operating hours, and calls routed through 988, and above all, prioritizes the self-determination of people with mental disabilities.

NYLPI urges the Council to amend B-HEARD by adopting the relevant provisions of an alternative program for a non-police response system proposed by CCIT-NYC. The CCIT-NYC proposal is based on CAHOOTS (Crisis Assistance Helping Out On The Streets), a highly successful Oregon program that has a 35-year track record of success responding to mental health crises without causing a single serious injury, much less any deaths.

The City, via its Mayor's Office of Community Mental Health (formerly ThriveNYC), introduced the B-HEARD pilot program in 2021 that it contends is responsive to the need to cease the killings at the hands of the police of individuals experiencing mental health crises. Unfortunately, that is simply not the case, despite the City's glowing description of the program. Among B-HEARD's grim statistics are the following:

- An astronomical **84% of all calls** in B-HEARD precincts continue to be **directed to the NYPD** two years after its kick-off.
- Even when all kinks are ironed out, the City anticipates continuing to have a nearly-as-astronomical **50% of all calls directed to the NYPD**.
- Moreover, **all calls continue to go through 911,** which is under the NYPD's jurisdiction.

- The entire **program is run by the NYPD and other City agencies**, with ***NO* role whatsoever for community organizations**. And there is not even any delineation of the lines of authority and communication among the various city agencies.
- **The crisis response teams are composed of emergency medical technicians (EMTs) who are employees of the City's Bureau of Emergency Medical Services (EMS) who are deeply enmeshed in the current police-led response system**. Peers and their families therefore do not trust these EMTs and are unlikely to reach out to them for assistance. The other team members are *licensed clinical* social workers. The licensure and clinical orientation requirements are unnecessary and they also preclude a vast array of potential candidates who have excellent skills and a long history of working with people experiencing crises.
- B-HEARD has ***NO* requirement to hire peers**.
- **The training of the teams does *NOT* require a trauma-informed framework, need *NOT* be experiential, and need *NOT* use skilled instructors who are peers or even care providers.**
- The anticipated **response time for crisis calls could be as long as half an hour**, and when last reviewed averaged over **fifteen minutes**, which is not even remotely comparable to the City's response times for other emergencies of 8-11 minutes.

- **The pilot operates only sixteen hours a day.**
- **There are no outcome/effectiveness metrics.**
- **There is no oversight mechanism.**

Correct Crisis Intervention Today – NYC has developed the needed antidote. Modeled on the CAHOOTS program in Oregon, which has successfully operated for over 30 years without *any* major injuries to respondents or responders – let alone deaths -- the CCIT-NYC proposal is positioned to make non-police responses available to those experiencing mental health crises in New York City. The proposal avoids the enormous pitfalls of the City's B-HEARD pilot, which it inaccurately refers to as a non-police model. Hallmarks of the CCIT-NYC proposal are:

- teams of trained peers and emergency medical technicians who are independent of city government;
- teams run by culturally-competent community organizations;
- response times comparable to those of other emergencies;
- 24/7 operating hours;
- calls routed to 988 rather than the city-operated 911; and
- oversight by an advisory board of 51% or more peers.

The full text of the CCIT-NYC proposal can be found at http://www.ccitnyc.org/whohttp://www.ccitnyc.org/who-we-are/our-proposal/we-are/our-proposal/, and a comparison of the CCIT-NYC proposal and the B-HEARD program is illustrated in the following chart:

Critical Attributes of a Mental Health Crisis Response System	CCIT-NYC's Proposal	NYC's B-HEARD Proposal
Removal of police responders	**YES**	**NO** (currently, 84% of calls are still responded to by police, and even when all kinks are removed, 50% of calls will still be responded to by police)
Three-digit phone number such as 988, in lieu of 911.	**YES**	**NO**
Response team to consist of an independent EMT and a trained peer who has lived experience of mental health crises and know best how to engage people in need of support	**YES**	**NO** (licensed clinical social worker and EMT employed by the New York City Bureau of Emergency Medical Services)
Crisis response program run by community-based entity/ies which will provide culturally competent care and will more likely have a history with the person in need and can intervene prior to a crisis	**YES**	**NO** (run by New York City Police Department and other City agencies)
Peer involvement in all aspects of planning/implementation/oversight	**YES**	**NO**
Oversight board consisting of 51% peers from low-income communities, especially Black, Latinx, and other communities of color	**YES**	**NO**

Creation/funding of non-coercive mental health services ("safety net"), including respite centers and 24/7 mental health care to minimize crises in the first place and to serve those for whom crisis de-escalation is insufficient	**YES**	**NO**
Response times comparable to those of other emergencies	**YES**	**NO** (Current response time of 15 minutes, 30 seconds -- compared with average response time of 8-11 minutes for non-mental health emergencies)
Response available 24/7	**YES**	**NO** (Response only available 16 hours/day)
Training of the teams to use a trauma-informed framework, be experiential, and use skilled instructors who are peers	**YES**	**NO**

NYLPI therefore urges the Council to ensure that the money previously allocated for a non-police mental health crisis response, be utilized solely for a truly non-police response such as the CCIT-NYC model, and not be utilized for the B-HEARD program in its current iteration.

The City must join other cities across the country – including Los Angeles, San Francisco, Albuquerque, Denver, New Haven and many more – to ***remove*** **police** – except in the rare instance where there is an imminent risk of serious physical harm -- and **ensure that *healthcare* workers respond to *healthcare* crises**.

The City must establish a system whereby individuals who experience a mental health crisis receive appropriate services which will de-escalate the crisis and ensure their wellbeing and the wellbeing of all other New Yorkers. Only those who are trained in de-escalation practices should respond to a mental health crisis, and the most appropriate individuals to receive such training are peers and health care providers.[1] Reliance on police officers and EMS EMTs in these situations is in fact dangerous, as Oren Barzilay, a 25-year veteran of the EMS, stated at the February 6 City Council Hearing regarding Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan.[2] Barzilay testified that the police, who are trained to uphold law and order, are ill suited to deal with individuals experiencing mental health crises. New York's history of police killing 19 individuals who were experiencing crises in the last six years alone is sad testament to that. Eliminating the police as mental health crisis responders has been shown to result in quicker recovery from crises, greater connections with long-term healthcare services and other community resources, and averting future crises.[3]

---

[1] Martha Williams Deane, *et al.*, "Emerging Partnerships between Mental Health and Law Enforcement," Psychiatric Services (1999), http://ps.psychiatryonline.org/doi/abs/10.1176/ps.50.1.99?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&#/doi/abs/10.1176/ps.50.1.99?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed.

[2] https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=5993303&GUID=CFEF7D06-B00B-4B22-8D71-B74AD1529788&Options=&Search=.

[3] Henry J. Steadman, *et al.*, "A Specialized Crisis Response Site as a Core Element of Police-Based Diversion Programs," Psychiatric Services (2001), http://ps.psychiatryonline.org/doi/10.1176/appi.ps.52.2.219?utm_source=TrendMD&utm_medium=cpc&utm_campaign=Psychiatric_Services_TrendMD_0.

Notably, Barzilay also advised that having the NYPD and the EMS respond to mental health crises places additional and onerous burdens on EMS.[4]

The scores of people experiencing mental health crises who have died at the hands of the police over the years is a microcosm of the police brutality around the world. Disability is disproportionately prevalent in the Black community and other communities of color,[5] and individuals who are shot and killed by the police when experiencing mental health crises are disproportionately Black and other people of color. Of the 19 individuals killed by police in the last seven years, 16 – or greater than 80% -- were Black or other people of color.

The City Council simply cannot stand by while the killings continue. Now is the time to truly remove the police as responders to mental health crises. Lives are literally at stake.

---

[4] https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=5993303&GUID=CFEF7D06-B00B-4B22-8D71-B74AD1529788&Options=&Search=.

[5] Mayor's Office for People with Disabilities, "Accessible NYC" (2016), https://www1.nyc.gov/assets/mopd/downloads/pdf/accessiblenyc_2016.pdf.

THE COUNCIL MUST OVERTURN THE MAYOR'S NEW POLICY OF FORCIBLY REMOVING INDIVIDUALS PERCEIVED TO HAVE A MENTAL ILLNESS DIAGNOSIS AND PERCEIVED TO BE "UNABLE TO CARE FOR THEIR BASIC NEEDS," BUT WHO DO NOT PRESENT A DANGER TO THEMSELVES OR OTHERS

The Mayor's new Involuntary Removal Policy, which he announced on November 29, 2022, allows a police officer to detain an individual by force, and remove the individual to a psychiatric hospital, solely because the officer believes the individual has a mental disability and is unable to meet "basic needs" -- without any indication that the individual is a danger to themself or others.

The Policy is both immoral and illegal.

By failing to mandate that an individual is "conducting himself or herself in a manner which is likely to result in serious harm to the person or others," the Involuntary Removal Policy runs afoul of Section 9.41 of New York's Mental Hygiene Law, as well as myriad other federal and state constitutional and statutory provisions, including the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and New York City's Human Rights Law.

Details on the Involuntary Removal Policy remain scarce, but Mayor Adams' statements[6], as well as the City's November 28, 2022 press release and

[6] On November 29, 2022, Mayor Adams delivered an "Address on the Mental Health Crisis in New York City" transcript available at: https://www.nyc.gov/office-of-the-mayor/news/871-22/transcript-mayor-eric-adamsdelivers-address-mental-health-crisis-new-york-city-holds.

directive[7], make clear that city agencies have aggressively instituted involuntary removals by police officers who have little to no expertise in dealing with individuals with mental disabilities and who will be required to determine whether an individual should be forcefully detained against their will. The examples cited by Mayor Adams at his press conference illustrate how difficult it is for police officers to make these sorts of determinations and how likely it is that the rights of New Yorkers will be violated by the Involuntary Removal Policy. Mayor Adams' example of "the shadow boxer on the street corner in Midtown, mumbling to himself as he jabs at an invisible adversary," does not describe someone who is unable to care for their basic needs, let alone describe someone who meets the standard of serious danger to themselves or others. The City's Involuntary Removal Policy also contains no information about how an officer would even go about determining whether such shadow boxers are unable to take care of their basic needs or are merely exercising.

Notably, even the NYPD's union has raised questions about how the police are to implement the Involuntary Removal Policy, stating that the new policy

[7] The directive is captioned Mental Health Involuntary Removals and is available at: https://www.nyc.gov/assets/home/downloads/pdf/press-releases/2022/MentalHealth-Involuntary-Removals.pdf. Following the announcement, the City communicated the new policy to its police officers through a FINEST message dated December 6, 2022 (FINEST message). The FINEST message was posted on the docket in the Baerga et al. v. NYC et al., 21-cv-05762 (SDNY) (PAC) litigation, ECF/Docket # 123-1.

puts a strain on the "understaffed, overworked and underpaid" NYPD officers.[8] In addition, it has been reported that the NYPD was blindsided by the Mayor's announcement and was inadequately prepared to implement it,[9] and that hospitals have limited capacity to deal with the influx of people brought in under these circumstances.[10] We know of no mechanisms for tracking the City employees' work under the Involuntary Removal Policy, no reference to publicly reporting about the involuntary removals, and no mention of any oversight mechanism for the removals.

Additionally, eliminating police as first responders in all but the rarest of instances can improve police job satisfaction, as many police officers do not see these incidents as part of their job and would prefer not to respond to these calls.[11]

---

[8] Corey Kilgannon, *Plan Tests Tense Relationship Between N.Y.P.D. and Mentally Ill People*, N.Y. Times, (December 5, 2022), https://www.nytimes.com/2022/12/05/nyregion/mental-health-plan-nypd.html.

[9] Craig McCarthy, *NYPD was blindsided by Eric Adams' plan to involuntarily commit more mentally ill homeless people*, N.Y. Post (November 30, 2022), https://nypost.com/2022/11/30/nypd-blindsided-by-eric-adams-plan-to-commit-mentally-ill-homeless/.

[10] Ethan Geringer-Sameth, Despite State Budget Funding, Little Progress Bringing Psychiatric Beds Back Into Service, Gotham Gazette, November 28, 2022, https://www.gothamgazette.com/state/11696-nystate-budgetlittle-progress-psychiatric-beds-hochul-adams.

[11] Waters, *supra* note 16, at 867; Simmons et al., *supra* note 6, at 33; Toby Miles-Johnson & Matthew Morgan, *Operational Response: Policing Persons with Mental Illness in Australia*, 55 J CRIMINOLOGY 260, 260 (2022). Trevor Viersen, *Exploring Police Officers' Perceptions of Mobile Crisis Rapid Response Teams Within a Nodal Policing Framework*, (Theses and Dissertations, 2017).

The City must overturn the Mayor's Involuntary Removal Policy to ensure that countless New Yorkers are not subjected to unlawful detention and involuntary hospitalization just for exhibiting behavior perceived by a police officer to be unusual -- whether the individual has a mental disability or not and whether the individual is a danger to self or others or not.

NYLPI URGES THE COUNCIL TO ADOPT OUR PROPOSALS WITH RESPECT TO THE CURRENT LANGUAGE OF THE COUNCIL'S ROADMAP

Resolution T2023-3256

NYLPI strongly supports this Resolution which calls on the federal government to ensure that calls to 988 are routed based on geolocation rather than area code, but urges the Council to additionally call on the federal government to ensure that privacy safeguards are put in place to ensure that geolocation information is not inappropriately used to detain or involuntarily commit 988 callers.

Resolution T2023-3359

NYLPI supports the concept of expanding the availability of mental health professionals by increasing Medicaid reimbursement rates for behavioral health services, but the Council must limit the Resolution by ensuring that Medicaid reimbursement rates are only increased for *voluntary* behavioral health services.

Int. T2023-3363

NYLPI supports this bill which will ensure that greater outreach and education regarding mental health services are available to New Yorkers. We urge the Council to specifically note that all outreach and education -- whether via the internet, television, radio, print media – must be made available in accessible formats for all persons with disabilities.

Int. T2023-3365

NYLPI supports this bill which will mandate the creation of a database and interactive map of outpatient mental health services in New York. Here too, we urge the Council to specifically note that the database and the map must be made available in accessible formats for all persons with disabilities. In addition, we propose that the Council mandate that information about the individual providers, including professional degree, degree-granting institution, professional certification, and number of years in practice in New York and altogether, be added to the information to be made available "at a minimum."

Int. T2023-3364

NYLPI supports this bill which will collect data on involuntary removals, but urges the Council to add the following provisions:

1. The demographic information collected should include information about the individual's disability status;
2. Data should be collected regarding the length of each hospital stay, rather that the average length of each hospital stay;
3. The limitation on data collection and reporting related to "interfer[ance] with law enforcement investigations" should be defined and time-limited to ensure that data collection is not unnecessarily limited; and
4. Similarly, limiting data collection to instances when it might "otherwise conflict with the interests of law enforcement," is excessively broad and needs to be greatly narrowed so as not to eviscerate the entire record collection mandate.

Resolution T2023-3360

While NYLPI appreciates the Council's focus on increasing development of supportive housing, we believe this resolution is premature. The NY/NY agreements which we favor have indeed expired, but there are two separate housing plans in place -- the Empire State Supportive Housing Initiative (ESSHI) at the state level and NYC 15/15 at the city level. Replacing these current plans – which will be in place for another seven years – will significantly stall production and be antithetical to our desire to increase housing for the disability community. We

would, however, support more coordination between the State and the City regarding implementation of ESSHI and NYC 15/15, at this juncture.

Resolution 0088-2022

NYLPI strongly opposes this resolution which advocates repealing the "Institutions for Mental Disease" (IMD) exclusion from the Social Security Act to allow Medicaid funding of state hospital psychiatric stays.

In 1965, when Medicaid barred federal reimbursement for services provided to individuals ages 21-64 in IMDs -- which it defined as hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in diagnosing, treating, or caring for persons with mental disabilities and substance use disorders -- its intent was to encourage investment in community-based services, rather than institutions and thereby avoid segregating people with disabilities. That need to encourage investment in community-based services, rather than institutions, is even more critical today, and it is surely the intent of the City Council, which well recognizes the benefits of community-based services and integration of the disability community.

Notably, the IMD Exclusion is a prohibition on settings, not services. New York can therefore provide any service that is provided in an IMD in a non-institutional setting and it will then receive Medicaid reimbursement.

The disability community has always opposed repealing or modifying the IMD exclusion because it involves investing in institutional, rather than community-based, services. In the last decade, the disability community strengthened its resolve to fight the IMD exclusion waiver, because the exclusion was waived in 2012-2015 for eleven states and the District of Columbia through the federally-mandated Medicaid Emergency Psychiatric Demonstration (MEPD) program[12], and it did not work. The final evaluations of the MEPD[13] found **no decrease in emergency room admissions, no decrease in lengths of IMD stay, no decrease in general hospital admissions, no decrease in lengths of general hospital stays, no improvement in access to inpatient care, and no improvement in access to follow-up outpatient care. Individuals continued to cycle in and out of emergency rooms**. Equally critically, the MEPD program also **failed to demonstrate a cost savings to communities**.

There are also serious harms associated with even short stays in IMDs. In litigation in Illinois (one of the MEPD demonstration states), the court monitor found during facility visits that the facilities failed to provide active treatment, and sounded a "cause for alarm" about critical incidents such as sexual assault, abuse, neglect, and death.

---

[12] https://innovation.cms.gov/innovation-models/medicaid-emergency-psychiatric-demo.

[13] *See* https://www.mathematica.org/projects/medicaid-emergency-psychiatric-services-demonstration and https://innovation.cms.gov/files/reports/mepd-finalrpt.pdf.

Given all of these ills, it is clear that any weakening of the IMD exclusion would violate the "community integration mandate" (to avoid institutions and provide services in the most integrated setting appropriate) of the Americans with Disabilities Act, as interpreted by the U.S. Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999). As the *Olmstead* Court recognized, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life…and institutional confinement severely diminishes the everyday life activities of [such] individuals." 527 U.S. at 597.

THE CITY COUNCIL MUST ENSURE THAT NEW YORKERS HAVE ACCESS TO A WIDE RANGE OF VOLUNTARY NON-HOSPITAL, COMMUNITY-BASED MENTAL HEALTH SERVICES THAT PROMOTE RECOVERY AND WELLNESS, AS WELL AS A FULL PANOPLY OF COMMUNITY SERVICES, INCLUDING HOUSING, EMPLOYMENT, AND EDUCATION, BY ALLOCATING FUNDING FOR SUCH PROGRAMS

Since NYLPI was established nearly 50 years ago, we have prioritized advocating on behalf of individuals with mental health conditions, and we have consistently fought to ensure that the rights of individuals with mental health conditions are protected by every aspect of New York's service delivery system. Core to our work is the principle of self-determination for all individuals with disabilities, along with the right to access a robust healthcare system that is available on a *voluntary, non-coercive* basis.

We have long been on record opposing mandatory outpatient and inpatient treatment for insufficiently safeguarding the rights of persons with mental health concerns and failing to offer appropriate healthcare. New York City must invest in models of care that utilize trained peers instead of police as first responders, which will facilitate the successful implementation of harm reduction and de-escalation techniques during crises.

If individuals experiencing mental health crises or alcohol/drug addiction receive voluntary, community-based treatment, society will benefit from reduced incarceration.[14] Community-response programs also lead to net positive savings in terms of total government expenditure, both in direct savings (reduced policing costs) and indirect savings (reductions in incarceration and emergency room visits).[15]

We know how to help those with the most severe mental illness, but we fail to do so as a society by providing services that are insufficient or not held to the highest accountability. We face complete system failure, yet we have done little to correct the failure, and even point our fingers at those most affected by the system failure. We must stop the finger pointing and fix the system. We must invest in

[14] Ashna Arora & Panka Bencsik, *Policing Substance Use: Chicago's Treatment Program for Narcotics Arrests* (Working Paper, 2021).

[15] *See* Natania Marcus & Vicky Stergiopoulos, *Re-examining Mental Health Crisis Intervention: A Rapid Review Comparing Outcomes Across Police, Co-responder, and Non-police Models*, 30 HEALTH & SOC. CARE COMMUNITY, *supra* note 3, at 1674–75 (2022).

innovative, voluntary health programs. As we now surely know all too well, the police, who are steeped in law and order, are not well-suited to deal with individuals with mental health concerns. We must invest in supportive housing and the quality community services set forth below at p. 23.

CONCLUSION

NYLPI respectfully requests that the Council:

- .Enact into legislation and fund the CCIT-NYC proposal to create a non-police, peer-driven mental health crisis response that offers voluntary healthcare, operates 24/7, routes calls to 988 rather than the NYPD-operated 911, and above all, prioritizes the self-determination of individuals experiencing mental health crises;
- Ensure that any funding allocated to B-HEARD be spent on the CCIT-NYC proposal; and
- Ensure that New Yorkers have access to a wide range of non-hospital, community-based mental health services that promote recovery and wellness, as well as a full panoply of community services, including, housing employment, and education, by allocating funding for such programs.

Thank you for your consideration. I can be reached at (212) 244-4664 or RLowenkron@NYLPI.org, and I look forward to the opportunity to discuss how

best to provide for the needs of individuals with mental health diagnoses in New York City.

###

About New York Lawyers for the Public Interest

For nearly 50 years, New York Lawyers for the Public Interest (NYLPI) has been a leading civil rights advocate for New Yorkers marginalized by race, poverty, disability, and immigration status. Through our community lawyering model, we bridge the gap between traditional civil legal services and civil rights, building strength and capacity for both individual solutions and long-term impact. Our work integrates the power of individual representation, impact litigation, and comprehensive organizing and policy campaigns. Guided by the priorities of our communities, we strive to achieve equality of opportunity and self-determination for people with disabilities, create equal access to health care, ensure immigrant opportunity, strengthen local nonprofits, and secure environmental justice for low-income communities of color.

NYLPI's Disability Justice Program works to advance the civil rights of New Yorkers with disabilities. In the past five years alone, NYLPI disability advocates have represented thousands of individuals and won campaigns improving the lives of hundreds of thousands of New Yorkers. Our landmark victories include integration into the community for people with mental illness, access to medical care and government services, and increased accessibility of New York City's public hospitals. Working together with NYLPI's Health Justice Program, we prioritize the reform of New York City's response to individuals experiencing mental health crises. We have successfully litigated to obtain the body-worn camera footage from the NYPD officers who shot and killed individuals experiencing mental health crises. In late 2021, NYLPI and co-counsel filed a class action lawsuit which seeks to halt New York's practice of dispatching police to respond to mental health crises, and in the context of that lawsuit, seeks relief on behalf of individuals affected by the Mayor's Involuntary Removal Policy.

Community Voluntary Long-Term Innovations for At-Risk Individuals

Residential

Crisis Respite – Intensive Crisis Residential Program: OMH program: "a safe place for the stabilization of psychiatric symptoms and a range of services from support to treatment services for children and adults. are intended to be located in the community and provide a home-like setting." https://omh.ny.gov/omhweb/bho/docs/crisis-residence-program-guidance.pdf.

Crisis Respite (shorter term and less intensive): OMH Program: "Crisis Respite Centers provide an alternative to hospitalization for people experiencing emotional crises. They are warm, safe and supportive home-like places to rest and recover when more support is needed than can be provided at home. The Crisis Respite Centers offer stays for up to one week and provide an open-door setting where people can continue their daily activities. Trained peers and non-peers work with individuals to help them successfully overcome emotional crises. https://www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-respite-centers.page.

Peer Crisis Respite programs: OMH funded; Peer operated short-term crisis respites that are home-like alternatives to hospital psychiatric ERs and inpatient units. Guests can stay up to seven nights, and they can come-and-go for appointments, jobs, and other essential needs. Offers a "full, customizable menu of services designed to help them understand what happened that caused their crisis, educate them about skills and resources that can help in times of emotional distress, explore the relationship between their current situation and their overall well-being, resolve the issues that brought them to the house, learn simple and effective ways to feel better, connect with other useful services and supports in the community, and feel comfortable returning home after their stay." https://people-usa.org/program/rose-houses/.

Housing First: a housing approach that prioritizes permanent housing for people experiencing homelessness and frequently serious mental illness and substance use issues. Supportive services including substance use counseling and treatment are part of the model, but abstinence or even engagement in services is not required. https://endhomelessness.org/resource/housing-first/.

Soteria: a Therapeutic Community Residence for the prevention of hospitalization for individuals experiencing a distressing extreme state, commonly referred to as psychosis. We believe that psychosis can be a temporary experience that one works through rather than a chronic mental illness that needs to be managed. We practice the approach of "being with" – this is a process of actively staying present with people and learning about their experiences. https://www.pathwaysvermont.org/what-we-do/our-programs/soteria-house/.

Safe Haven: provides transitional housing for vulnerable street homeless individuals, primarily women. "low-threshold" resources: they have fewer requirements, making them attractive to those who are resistant to emergency shelter. Safe Havens offer intensive case management, along with mental health and substance abuse assistance, with the ultimate

goal of moving each client into permanent housing. https://breakingground.org/our-housing/midwood.

Family Crisis Respite: trained and paid community members with extra space in their homes provide respite for individuals who can thereby avoid hospitalization.

Living Room model: a community crisis center that offers people experiencing a mental health crisis an alternative to hospitalization. health crises a calm and safe environment. The community outpatient centers are open 24 hours a day, 7 days a week and people receive care immediately. Services include: crisis intervention, a safe place in which to rest and relax, support from peer counselors; intervention from professional counselors including teaching de-escalation skills and developing safety plans, Linkage with referrals for emergency housing, healthcare, food, and mental health services. https://smiadviser.org/knowledge_post/what-is-the-living-room-model-for-people-experiencing-a-mental-health-crisis.

Crisis Stabilization Centers: 24/7 community crisis response hub where people of all ages can connect immediately with an integrated team of clinical counselors, peer specialists, and behavioral health professionals, as well as to our local community's health & human service providers, to address any mental health, addiction, or social determinant of health needs. People use the Stabilization Center when they're experiencing emotional distress, acute psychiatric symptoms, addiction challenges, intoxication, family issues, and other life stressors. https://people-usa.org/program/crisis-stabilization-center/.

Parachute NYC / Open Dialogue: provides a non-threatening environment where people who are coming undone can take a break from their turbulent lives and think through their problems before they reach a crisis point. Many who shun hospitals and crisis stabilization units will voluntarily seek help at respite centers. Parachute NYC includes mobile treatment units and phone counseling in addition to the four brick-and-mortar respite centers. https://www.nyaprs.org/e-news-bulletins/2015/parachute-nyc-highlights-success-of-peer-crisis-model-impact-of-community-access.

Non-residential

Safe Options Support teams: consisting of direct outreach workers as well as clinicians to help more New Yorkers come off of streets and into shelters and/or housing**.** SOS CTI Teams will be comprised of licensed clinicians, care managers, peers, and registered nurses. Services will be provided for up to 12 months, pre- and post-housing placement, with an intensive initial outreach and engagement period that includes multiple visits per week, each for several hours. Participants will learn self-management skills and master activities of daily living on the road to self-efficacy and recovery. The teams' outreach will facilitate connection to treatment and support services. The SOS CTI Teams will follow the CTI model – a time-limited, evidence-based service that helps vulnerable individuals during periods of transitions. The teams will be serving individuals as they transition from street homelessness to housing. https://omh.ny.gov/omhweb/rfp/2022/sos/sos_cti_rfp.pdf.

Intensive and Sustained Engagement Team (INSET): a model of integrated peer and professional services provides rapid, intensive, flexible, and sustained interventions to help individuals who have experienced frequent periods of acute states of distress, frequent emergency room visits, hospitalizations, and criminal justice involvement and for whom

prior programs of care and support have been ineffective. MHA has found that participants, previously labeled "non-adherent," "resistant to treatment" or "in need of a higher level of care" and "mandated services," become voluntarily engaged and motivated to work toward recovery once offered peer connection, hope and opportunities to collaborate, share in decisions and exercise more control over their lives and their services and supports. their treatment plans. Engaged 80% of people either AOT eligible or AOT involved. https://www.mhawestchester.org/our-services/treatment-support.

NYAPRS Peer Bridger™ program: a peer-run and staffed model providing transitional support for people being discharged from state and local hospitals, with the goal of helping people to live successfully in the community, breaking cycles of frequent relapses and readmissions. The program include inpatient and community based intensive one on one peer support groups, discharge planning, connection to community resources; provides access to emergency housing, wrap around dollars and free cell phones and minutes. https://www.nyaprs.org/peer-bridger.

NYC Mayor's Office of Community Mental Health Intensive Mobile Treatment teams: provide intensive and continuous support and treatment to individuals right in their communities, where and when they need it. Clients have had recent and frequent contact with the mental health, criminal justice, and homeless services systems, recent behavior that is unsafe and escalating, and who were poorly served by traditional treatment models. IMT teams include mental health, substance use, and peer specialists who provide support and treatment including medication, and facilitate connections to housing and additional supportive services. https://mentalhealth.cityofnewyork.us/program/intensive-mobile-treatment-imt.

Pathway Home™: a community-based care transition/management intervention offering intensive, mobile, time-limited services to individuals transitioning from an institutional setting back to the community. CBC acts as a single point of referral to multidisciplinary teams at ten care management agencies (CMAs) in CBC's broader IPA network. These teams maintain small caseloads and offer flexible interventions where frequency, duration and intensity is tailored to match the individual's community needs and have the capacity to respond rapidly to crisis. https://cbcare.org/innovative-programs/pathway-home/.

FROM NEGLECT AND ABUSE TO HEALING COMMUNITIES: A MENTAL HEALTH ACTION PLAN FOR NEW YORK CITY

Presented by:

THE COALITION FOR RIGHTS-BASED MENTAL HEALTH CARE

Mental Health and Social Justice: A Call for Change

New York City's public mental health services are dysfunctional -- from policies to procedures to programs to facilities -- and the system's negative impact on Black and Brown communities existed long before the Coronavirus pandemic came along and turned what was a dire situation into a human rights crisis.

On January 1, 2022, a new Mayor will be sworn in. Our goal in creating this document is to provide a list of practical recommendations to help the next Mayor effectively address issues that are central to the lives of all New Yorkers. The road to creating a *comprehensive, linguistically, culturally, and gender competent, and person-centered* mental health system will require the next Mayor to take urgent, forward-thinking, and concrete action. To achieve this, the next Mayor must work with the communities disproportionately impacted by mental health concerns to develop an action plan that focuses both on the systems at work, together with the underlying social determinants which undermine mental health care: lack of accessible services, limited housing options, virtually non-existent social supports, high unemployment and underemployment, racism, and police violence. Notably, those with the highest needs, including people who are homeless or incarcerated, have the least access to care.

Mental health falls at the intersection of two public perceptions. On one side, mental health advocacy groups and championing policymakers recognize the urgency to act and understand that mental health is a social justice and human rights issue, not just a public health concern. On the other side, a prevailing mindset remains, shaped by worries over public safety and threat elimination. This perception unfortunately prompts government officials to mandate coercive mental health treatment and deploy the police as a crisis management force. The result is devastating—more disadvantaged New Yorkers experiencing mental health concerns end up in jails instead of wellness centers, and there are more individuals in jails with mental concerns than are in hospitals, let alone than are receiving services in the community.

A Crisis System in Disarray

Because of mental health service gaps in our city, a mental health crisis is far more likely to be responded to by police officers than health professionals. While the overall number of mental health-related 911 calls has decreased slightly in the past few years, they have *increased in Black and Brown communities*. Police violence disproportionately impacts communities of color, with *Black Americans* killed at 2.6 times the rate of white people and Hispanic Americans killed at nearly 1.3 times the rate of white people.[1] And *those with disabilities are at even greater risk*. Despite over 20,000 New York Police Department (NYPD) personnel trained in state-of-the-art crisis de-escalation techniques, since 2015 alone, eighteen New Yorkers experiencing a mental health crisis were killed by the police, of which *fifteen were people of color*.[2]

Prevention: A More Effective and Less Costly Alternative

The inordinate number of mental health crisis calls (roughly 200,000 annually) are a symptom of a system that favors paying for care after people experience a mental health issue, instead of providing services and supports that promote health and wellness. And the care that is delivered, especially for people reliant on the public mental health system, is routinely second-rate, dismissive of customer choice or convenience, and difficult to obtain in many neighborhoods.

Value-based service payment models have been promised for over a decade, but have been largely stymied by an entrenched healthcare industry which resists reimbursement models that pay for health, housing and social outcomes over mere service utilization that depends on occupied beds, repeat clinic visits, overuse of prescription medication, and insurance premiums that pay for care that may not be of any benefit.

Preventive care would result in keeping people healthy through the provision of social supports starting with economic security, safe affordable housing, available employment, meaningful social connections (including clubhouses which have recently expanded in the City), psychosocial rehabilitation services, and the ability to access beneficial services in one's own community.

Mental Health Reform Priorities

The next Mayoral administration in New York City will inherit this failed mental health and mental health crisis response system, and the public will demand answers. The Mayoral candidates must consider the untapped potential of communities -- moving from a trauma focus to a health equity lens that addresses bias -- and identify a shared vision that lifts and activates the community's voice, participation, and leadership. The following actions must be taken to reform the city's mental health system:

1

Ensure access to compassionate and voluntary mental health programs and services that are rights-based, all-inclusive, person-centered, free of coercion, community-driven, and linguistically, culturally, and gender appropriate.

2

Divert people with mental health concerns from the criminal legal system by cutting the school-to-prison pipeline, ending over-policing in communities of color, and embracing the national “Stepping Up” mental health criminal legal initiative.

3

Develop a non-police response to mental health crises and dismantle the vicious cycle of criminalization, avoidable and very costly emergency room and inpatient utilization, incarceration, unemployment, and homelessness that robs New Yorkers with mental health conditions of their dignity, liberty, and ability to thrive.

4

Support peers (persons with lived mental health experience), their family members and friends, in their homes and neighborhoods -- not “safety net” hospitals -- by skilled practitioners drawn from the same culture.

5

Ensure that employment opportunities are free from discrimination and available to the mental health community so that individuals can secure and succeed at competitive employment.

6

Vastly expand the stock of quality affordable and supportive housing, ensuring that access is targeted to low- and modest-income populations, people who are homeless, those formerly incarcerated, and populations of color.

5

ISSUE

PROVIDE RIGHTS-BASED, PERSON-CENTERED MENTAL HEALTH SERVICES

New York City must eliminate coercive and punitive mental health treatments and ensure access to compassionate and voluntary mental health programs and services that are rights-based, all-inclusive, person-centered, free of coercion, community-driven, and linguistically, culturally, and gender appropriate. Further, New York City can take advantage of existing state and federal waivers to implement value-based models that support these principles. We need non-coercive services that are linguistically, culturally and gender relevant and engage peers in the workforce.

EVIDENCE

- • New York City relies on a series of costly, coercive, often harmful and largely ineffective services that the majority of persons with mental health concerns abhor, including involuntary psychiatric hospitalization, hospital-based psychiatric emergency departments, mobile services such as Assertive Community Treatment (ACT), and "Assisted" Outpatient Treatment (AOT), medications that are often disabling or even life-threatening, and inadequate and generally punitive approaches to substance use and dependency. In fact, the positive outcomes are the result of connection to services, not forced treatment.[3]
- • Data on the risks, benefits, and limitations of involuntary psychiatric treatment and hospitalization are still very limited and subject to many interpretations.[4]
- • There is a growing recovery movement which recognizes that the current drug-based paradigm of care has failed our society, and that scientific research, as well as lived experience, calls for profound change.[5]

RECOMMENDATIONS

Increase and adequately fund (*e.g.*, via block grant/ CORE) the following essential services:

- • A continuum of rights-conforming and humane crisis supports, which include accessible walk-in crisis services that are not hospital-based
- • Drop-in and club-like community centers and clubhouses, without constraints on participation
- • Voluntary medium-stay residential settings, e.g., Soteria Houses or open ward inpatient units
- • Home care and support teams with significant peer participation that include access to primary care
- • Extensive harm-reduction supports for persons engaging in substance use and other risky behaviors
- • Psychosocial rehabilitation services to assist people living with mental health concerns in building emotional, cognitive, and social skills to help them live and work in their communities as independently as possible
- • Non-medical supports and interventions, such as intensive, interpersonal psychotherapy and counseling specifically designed for persons with traumatic experiences and significant mental health concerns, healing methodologies such as acupuncture, meditation, guided physical exercise, and proven natural remedies.

6

DIVERT PEOPLE WITH MENTAL HEALTH CONCERNS FROM THE CRIMINAL LEGAL SYSTEM

ISSUE

People of color are more dependent on the public mental health system, which offers few services in high-need communities. At the same time, Black and Brown people, especially men with mental health concerns, are more likely to have encounters with law enforcement, be charged for a crime, and be held in jail. People living with mental health and substance use concerns are no more violent than the general population, yet they represent roughly half the detainees in our jails.[6]

EVIDENCE

- • New York City's mental health system is failing to support Black and Brown people living in high-need communities. The stress and trauma of life in these communities is manifest in high rates of illness, poverty, and involvement in the criminal legal system.
- • The interplay among poverty, homelessness, mental health, and criminal legal involvement is well established: Black and Brown people are over-represented in all of these categories, and it is the reason people of color represent 86% of those detained in city jails on any given day[7] and that 46% have a known mental health condition, a rate that has increased from 29% since 2010, even as the overall jail population has dropped dramatically.[8]
- • Addressing the social and health issues of people with mental health concerns in the criminal legal system has been the focus of ongoing reform efforts and was addressed most recently by two major government task force projects, which produced 66 different recommendations aimed at diverting people with mental health concerns from the criminal legal system.[9] Nonetheless, people with serious mental health concerns continue to enter our criminal legal system in unprecedented numbers.
- • Schools send students into the criminal legal system through disciplinary policies that are disproportionately applied to children of color, youth with disabilities, and LGBTQ students. These practices involve the police in minor misbehavior and often lead to arrests and juvenile detention referrals. Suspensions and expulsions have been shown to correlate with a young person's probability of dropping out and becoming involved with the criminal legal system. Once a child drops out, they are eight times more likely to be incarcerated than youth who graduate from high school.[10] Further, there is nearly a 70 percent chance that a Black man without a high school diploma will be imprisoned by his mid-thirties.[11]

RECOMMENDATIONS

- • Implement community-designed and staffed diversion centers with respite and drop-in components.

7

- • Expand Neighborhood Health Action Centers to include supports and services that integrate agencies and programs for youth and persons with mental health concerns related to issues of re-entry, school, and maternity.
- • Expand re-entry programs for people living with mental illness released from prisons and jails.
- • Establish a city agency responsible for mental health concerns and track outcomes for frequent callers.
- • Employ diversion strategies to avoid interaction with criminal legal systems.
- • End the school to prison pipeline.
- • Provide positive peer supports for young people to avoid the criminal legal system.
- • Address crisis with non-criminal legal lens.
- • Utilize best practice approaches that employ peer input from planning to orchestration to outcome measurement and review.
- • Embrace alternative-to-incarceration models that target young people of color.
- • Recognize that all approaches to seeking safety require person-centered, trauma-informed care.

8

DEVELOP A NON-POLICE RESPONSE FOR PEOPLE EXPERIENCING A MENTAL HEALTH CRISIS

ISSUE

New York City's current police-run mental health crisis response system has resulted in multiple deaths of individuals experiencing mental health crises, as well as countless injuries and extensive trauma, great overuse of involuntary psychiatric hospitalization and other forced treatment, and extensive involvement with the criminal legal system. The system fails to incorporate the latest standards in crisis de-escalation and is not responsive to the concerns of affected communities, especially communities of color.

EVIDENCE

- • For far too long, the mental health community has faced recurring and relentless trauma at the hands of the police and other first responders to mental health crises. Since 2016 alone, the New York City Police Department has killed 18 people experiencing mental health crises, 15 of whom were people of color.[12]
- • New York City's Emergency Medical Services (EMS), recommended by the current mayor to replace police as responders in certain instances, has made it clear that it does not want its staff to be responders; indeed, EMS reports already struggling to fill positions at the pilot stage.[13] Further, EMS is often a first responder under the current system, which has failed our City and does not have the support of people with disabilities.
- • While the City's police-run model has resulted in countless deaths and myriad injuries, Crisis Assistance Helping Out On The Streets (CAHOOTS)[14] in Eugene, Oregon has run its non-police model successfully for well over 30 years without a single injury to persons experiencing mental health crises or to its responders.[15] CAHOOTS, with its corps of independent emergency medical technicians and civilian crisis workers -- the vast majority of whom are peers, and all of whom received a minimum of 500 hours of on-the-ground training in crisis counseling, conflict resolution, and medical care -- is the basis for the model proposed for the city by Correct Crisis Intervention Today - NYC (CCIT-NYC) and also serves as the model for response systems across the country, including those in Los Angeles, Denver, San Francisco, New Haven, and an ever-growing list of other cities.
- • The NYPD began providing state-of-the-art Crisis Intervention Team (CIT) training in June 2015. In the four and a half ensuing years, however, more mental health recipients were fatally shot by the police than previously.
- • Not surprisingly, many individuals with mental health concerns, their family members, and health providers fear calling 911 because of these and other similar tragedies. This causes many people to delay reaching out for help until circumstances have escalated to a critical stage.

9

- • CIT International -- a group consisting primarily of police, which created crisis intervention team (CIT) training 35 years ago -- now argues that only a mental healthcare response is appropriate for a mental health crisis.
- • The Mayor's recent bold budget allocation of $112M to crisis response services is much needed and long overdue. Using these funds to establish a peer-driven, community-based mental health response system that eliminates police entirely will greatly enhance the lives of all New Yorkers.

RECOMMENDATIONS

- • New York City's current mental health crisis response system must be replaced by a non-police response system with a team consisting of one peer trained as a crisis counselor and one independent emergency medical technician (EMT).
- • Peers -- especially those from low-income Black, Latinx and other communities of color -- must be involved in all stages of the planning, design, implementation, maintenance, and evaluation of the alternate crisis response system.
- • The focus of non-police crisis response teams must be preventative in nature and must target hot spots and repeat callers.
- • Call response times must be equivalent to 911 response times.
- • All calls must be re-routed from the police-run 911 to another three-digit number, with consideration given to the national 988 suicide hotline.
- • The City should participate in a learning collaborative with other cities piloting non-police crisis response programs across the country to measure outcomes and build experience.

10

BRING SUPPORT SERVICES INTO HOMES AND LOCAL COMMUNITIES

ISSUE

The vast majority of persons with mental health concerns now live in the community, yet cannot access support services in or near their homes. Many receive care and support from family members, friends, and other concerned individuals, but the current system does not recognize or reimburse that care and support. Others are without supportive family or friends, as not all family and friend situations are conducive to mutual support and thriving. Blaming families for causing mental health concerns increases distress, especially in situations where families are expected to act as caregivers and resources, and where resources for both those with mental health concerns and their caregivers are scarce.

EVIDENCE

- • Just and accountable home- and community-based programs and services benefit individuals with mental health concerns and their families alike.
- • Housing shortages require families to maintain hands-on caregiving roles for people leaving public institutions, even when the person with mental health concerns might prefer to live more independently.
- • Families and other supporters have been unnecessarily excluded from treatment and care plans when their input does not violate privacy mandates of the Health Insurance Portability and Accountability Act (HIPAA).
- • Despite some innovative programs, access to peer support is still minimal.
- • Mental health professionals are not trained in engaging and working with families and other supporters or in collaborating with peer support workers.[16]
- • Bureaucratic priorities and institutional practices have contributed to undermining the relationship between people with mental health concerns and their families, and have led to adversarial outcomes, especially when families are recruited by police, courts, hospitals, doctors, and Medicaid to become enforcers of their priorities.

RECOMMENDATIONS

- • Make home- and community-based supports, including peer support and personal care attendants, available to people with mental health concerns.
- • Decriminalize crisis assistance to encourage people to seek help, including an appropriate non-police response to crises, and in-home support, accessible crisis residential alternatives, crisis mobile teams, and walk-in crisis centers that are not hospital-based.

11

- • Expand supportive housing and affordable housing options and make respite options available for persons experiencing a mental health crisis. Ensure supportive housing is available for the partners and young children of people with mental health concerns.
- • To the extent authorized by the person with mental health concerns, engage peers, family members, and other community supporters as partners and active caregivers.
- • Make resources available for caregiving families, peers, and other supporters to prevent crises, during a crisis, and beyond.
- • When families or other caregivers provide basic assistance to individuals with mental health concerns, they should be provided with financial assistance, either directly or through additional stipends issued to the person with mental health concerns.
- • Assist persons with mental health concerns who wish to stay in touch with their families or other supporters.
- • Ensure crisis response systems include programming and supports for family members.
- • Include families as part of the peer's active career efforts, to the extent authorized by the peer.

12

ENSURE THAT COMPETITIVE EMPLOYMENT IS AVAILABLE TO PEOPLE WITH MENTAL HEALTH CONCERNS

ISSUE

Individuals with mental disabilities encounter myriad barriers in the workplace caused by signs of the individual's disability, stigma associated with the disability, reluctance to hire individuals with mental health concerns, refusal to provide accommodations for the disability, and other discrimination.[17] The barriers result in unemployment, underemployment, and discrimination, all of which further adversely impact mental health.[18]

EVIDENCE

- • Individuals with mental disabilities struggle with obtaining stable employment.[19] Additionally, further discrimination lowers the probability that members of this stigmatized group will be hired, and their wages are significantly reduced if they are.[20]
- • Individuals with severe mental disabilities are seven times more likely to be unemployed than people without disabilities.[21]
- • Among adults served in New York's public mental health system, 64.4% of those 18–20, 66.6% of those 21–64, and 91.9% of those 65 or older are unemployed.[22]
- • Similarly, individuals with mental disabilities experience disproportionately high rates of underemployment. For instance, only 33.7% of individuals with a mental disability work full-time, compared to 62.4% of individuals with no known mental disability.[23]

This disparity is even more pronounced among individuals with more serious or stigmatized mental health concerns—for example, only 12% of individuals with schizophrenia worked full time.[24]

- • Stigma and discrimination contribute to unemployment and underemployment among individuals with mental health concerns.[25]
- • Approximately 70% of employers are reluctant to hire someone with mental disabilities.26
- • Nearly a quarter of all employers would dismiss someone who had not disclosed a mental disability.[27]
- • Fearing stigma, many workers conceal disabilities and miss out on available supports.[28]
- • Stigma prevents people with mental disabilities from seeking healthcare for fear of being treated differently.
- • Employees with mental disabilities report experiencing discrimination from co-workers, feeling socially marginalized, needing to cope with negative comments, and being placed in positions of reduced responsibility.[29]
- • The long-term effects of stigma are worsening health problems which result in increased sick leave and loss of employment.[30]

13

- • Fewer than 2% of people served in state mental health systems received supported employment services.[31]

RECOMMENDATIONS

- • Ensure compliance with the federal, state, and local non-discrimination laws to eliminate discrimination in employment based on mental health concerns, including elimination of intersectional discrimination based on race and previous involvement in the criminal legal system.
- • Allocate funds to support transition services for Supplemental Security Income (SSI) beneficiaries and Medicaid enrollees who gain employment and enroll in private health coverage.
- • Provide SSI and Social Security Disability Insurance (SSDI) recipients with individualized, wrap-around benefits advice and work incentive counseling.
- • Provide single points of contacts to help employers understand the benefits of hiring workers with mental disabilities and to help them navigate the rules and resources pertaining to hiring individuals with disabilities.
- • Assist employers to leverage federal financial incentives such as payroll tax credits to encourage businesses to hire people with disabilities.
- • Bring rapid-placement vocational programs to scale for individuals with mental disabilities.
- • Make age-appropriate supported education and employment services available to young adults with mental disabilities.
- • Identify competitive employment as a critical measure of mental health care provider success and a driver of provider priorities.
- • Integrate and improve employment data reporting and analytics to better understand and respond to need, track progress, assess impact of intervention/policies and incentivize performance across all systems.
- • Expand the provision of psychosocial rehabilitation – which began 73 years ago right here in NYC at Fountain House and now is spread through all five boroughs in other clubhouses as well as a variety of organizations throughout the city – by New York City's Department of Health and Mental Health (DOHMH), including education support services, pre-vocational services, transitional employment, intensive supported employment, and ongoing supported employment, including clubhouses.
- • Support expansion of the evidence-based Individual Placement and Support (IPS) model of supported employment for people with living with mental health concerns, to embed specially trained peers (individuals with lived mental health experience) in multiple settings, and develop adequate, long-term financing mechanisms to implement such services.

14

MAKE INTEGRATED AFFORDABLE HOUSING AVAILABLE TO END HOMELESSNESS AND PROMOTE WELLBEING

ISSUE

Individuals with mental health concerns face extensive homelessness which is caused by a lack of affordable and integrated supportive housing.

EVIDENCE

• Housing -- meaning a place where a person can reliably and safely have undisturbed sleep every night -- is essential for one's health and especially mental health.

• • Homelessness is largely an issue of rent burden and the lack of adequately-funded accessible, affordable, and supportive housing in our city, and it has its roots in racial segregation, state and federal mental health and welfare policy, and the vagaries of the New York real estate market.

• • In this pandemic-filled era in New York City, homelessness has surpassed record numbers and many households are a paycheck or health crisis away from losing their place to live.[32]

• • Even before the pandemic, New York City was experiencing a homelessness crisis, with both single and family homeless census numbers topping record numbers. The COVID-19 crisis dramatically underscored the fact that housing is not just a healthcare matter, but a matter of life and death.[33]

• • Access to affordable housing is rife with discrimination and remains the primary barrier to solving homelessness.[34]

• • The COVID Relief bill brought $6 billion in federal relief to New York City, yet many New Yorkers are homeless and do not have paths to permanent housing, and City subsidies pay today what Section 8 paid in 2005.[35]

• • Housing vouchers are key to helping people avoid or exit homelessness, but many New Yorkers with vouchers still struggle to find an apartment so they can move out of shelters. A major barrier to using housing vouchers is that the City's main subsidy program, City Family Homelessness & Eviction Prevention Subsidy (FHEPS), sets the maximum rent levels unrealistically low for New York City's expensive housing market.

• • Although New York has developed 40,000 units of permanent supportive housing for individuals with mental health concerns that respect tenant rights and promote wellbeing in community-based settings overseen by non-profit agencies, the need is at least double that. Moreover, for decades, these programs have been woefully underfunded, trending 40% below the cost of inflation and preventing both recruitment of a qualified workforce and adequate expansion to meet increasing demand.

15

- • Outreach programs to engage homeless individuals are critical to decreasing homelessness.

RECOMMENDATIONS

- • Develop more supportive housing ensuring that access is targeted to low- and modest-income populations, people who are homeless, formerly incarcerated, and populations of color.
- • Demonstrate a commitment to keeping our communities safe, healthy, and free of racism, with accessible healthcare and protection from police violence.
- • Pass Int. 146 to increase the City's FHEPS subsidy to a functional rent rate.
- • Pass Int. 2047 to end discrimination in affordable housing.
- • Ensure 2021-22 budget includes proposed funding to expand the Empire State Supportive Housing Initiative (ESSHI) housing development, preserve existing housing stock and reinvest savings correctly into the community through relief to the housing budget.
- • Advance supportive housing underwriting and service delivery funding options that incentivize development of projects that incorporate elements of fuller community integration, such as economic/income level integration, family inclusion, and decreasing the ratio of individuals living with mental health concerns versus those without such concerns.
- • Ensure compliance with the federal, state, and local non-discrimination laws to eliminate discrimination in housing based on mental health concerns, including elimination of intersectional discrimination based on race and previous involvement in the criminal legal system.

16

THE COALITION FOR RIGHTS-BASED MENTAL HEALTH CARE

504 DEMOCRATIC CLUB
BRONX INDEPENDENT LIVING SERVICES
BROOKLYN CENTER FOR INDEPENDENCE OF THE DISABLED
CENTER FOR INDEPENDENCE OF THE DISABLED, NY
COMMUNITY ACCESS, INC.
CONCERN FOR INDEPENDENT LIVING, INC.
DISABILITY RIGHTS NEW YORK
FOUNTAIN HOUSE
HARLEM INDEPENDENT LIVING CENTER
INDEPENDENCE CARE SYSTEM
JOHN JAY COLLEGE INSTITUTE FOR JUSTICE AND OPPORTUNITY
LEGAL ACTION CENTER
THE LEGAL AID SOCIETY
MOBILIZATION FOR JUSTICE
NATIONAL ALLIANCE ON MENTAL ILLNESS OF NYC (NAMI-NYC)
NEW YORK ASSOCIATION OF PSYCHIATRIC REHABILITATION SERVICES
NEW YORK LAWYERS FOR THE PUBLIC INTEREST
STATEN ISLAND CENTER FOR INDEPENDENT LIVING
URBAN JUSTICE CENTER – FREEDOM AGENDA

CELIA BROWN
STEVE COE
CAL HEDIGAN
RUTH LOWENKRON
JAMES MUTTON
HARVEY ROSENTHAL
CHRISTINA SPARROCK
PETER STASTNY
LAURA ZIEGLER

17

ENDNOTES

[1] Brita Belli, "Racial disparity in police shootings unchanged over 5 years," *Yale News*, October 27, 2020, https://news.yale.edu/2020/10/27/racial-disparity-police-shootings-unchanged-over-5-years.
[2] https://www.nylpi.org/wp-content/uploads/2021/05/CCITNYC-pictures-of-individuals-killed-final.png.
[3] Robert Whitaker & Michael Simonson, "Twenty Years After Kendra's Law: The Case Against AOT," *Mad in America*, July 14, 2019, https://www.madinamerica.com/2019/07/twenty-years-kendras-law-case-aot/.
[4] Robert L. Trestman, "Committed: The Battle over Involuntary Psychiatric Care," *Journal of the American Academy of Psychiatry and the Law Online* 45, no. 4 (2017): 513-514, http://jaapl.org/content/45/4/513.
[5] Mad in America, "Missions Statement," *Mad in America: Science, Psychiatry, and Social Justice*, https://www.madinamerica.com/about-us/.
[6] Bureau of Justice Statistics, "Special Report: Mental Health Problems of Prison and Jail Inmates," *U.S. Department of Justice Office of Justice Programs*, December 14, 2006, https://www.bjs.gov/content/pub/pdf/mhppji.pdf.
[7] City of New York Correction Department, "NYC Department of Correction at a Glance," 2019, https://www1.nyc.gov/assets/doc/downloads/press-release/DOC_At%20a%20Glance-1st6_Months_FY2019_012919.pdf.
[8] Dean Fuleihan and Jeff Thamkittikasem, "Mayor' Management Report," *The City of New York: Mayor Bill de Blasio*, September, 2020, https://www1.nyc.gov/assets/operations/downloads/pdf/mmr2020/2020_mmr.pdf; Mayor's Task Force on Behavioral Health and the Criminal Justice System, "Action Plan," *City of New York: Mayor Bill de Blasio*, 2014, https://www.communityaccess.org/storage/images/Knowledge_Base/Behavioral_Health_and_Criminal_Justice_System_Action_Plan.pdf.
[9] Mayor's Task Force on Behavioral Health and Criminal Justice, "First Status Report," *City of New York: Mayor Bill de Blasio*, August 2015, http://criminaljustice.cityofnewyork.us/wp-content/uploads/2018/04/BHTF-First-Status-Report-8.15.pdf; New York State/New York City Mental Health-Criminal Justice Panel, "Report and Recommendations," June 2008, https://omh.ny.gov/omhweb/justice_panel_report/report.pdf.
[10] Judah Schept, Tyler Wall, and Avi Brisman, "Building, Staffing, and Insulating: An Architecture of Criminological Complicity in the School-to-Prison Pipeline," *Social Justice* 41, no. 4 (138 (2014): 96-115.
[11] Melissa S. Kearney and Benjamin H. Harris, "Ten Economic Facts about Crime and Incarceration in the United States," *Brookings Institute*, May 1, 2014, https://www.brookings.edu/research/ten-economic-facts-about-crime-and-incarceration-in-the-united-states/.
[12] New York Lawyers for the Public Interest, "Press Release: Advocates Applaud Mayor's $112M Mental Health Crisis Response Allocation, Yet Call for Complete Removal of Police and Urge Involvement of Peers and Affected Communities," *NYLPI*, May 3, 2021, https://www.nylpi.org/advocates-applaud-mayors-112m-mental-health-crisis-response-allocation-yet-call-for-complete-removal-of-police-and-urge-involvement-of-peers-and-affected-communities/.
[13] Nolan Hicks and Gabrielle Fonrouge, "Social Workers and EMS to respond to mental health emergencies NYC-wide," New York Post, April 26, 2021, https://nypost.com/2021/04/26/nyc-social-workers-and-ems-to-take-mental-health-emergencies/.
[14] Anna V. Smith, "There's already an alternative to calling the police," High Country News, June 11, 2020, https://www.hcn.org/issues/52.7/public-health-theres-already-an-alternative-to-calling-the-police.
[15] New York Lawyers for the Public Interest, "Establishing a Non-Police Response to Mental Health Crises: The Needless Killing of Miguel Richards by NYC Police," Facebook Webinar Series, November 12, 2020, https://www.facebook.com/NewYorkLawyersforthePublicInterest/videos/657173338180022/.
[16] Margaret Leggatt, "Families and mental health workers: the need for partnership," *World Psychiatry* 1, no. 1 (2002): 52, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489835/.
[17] Center for Psychiatric Rehabilitation, "Barriers to Employment for Those With Severe Mental Illness," *Boston University*, https://cpr.bu.edu/wp-content/uploads/2020/04/Barriers-to-Employment.pdf.
[18] Alison Milner, Tania Louise King, Anthony D LaMontagne, Zoe Aitken, Dennis Petrie, and Anne M Kavanaugh, "Underemployment and its impacts on mental health among those with disabilities: evidence from the HILDA cohort." *J Epidemiol Community Health* 71, no. 12 (2017): 1198-1202.
[19] *See* Jenny Gold, "Report: Adult with Serious Mental Illnesses Face 80% Unemployment," *KHN News*, July 10, 2014, https://khn.org/news/report-adults-with-serious-mental-illnesses-face-80-unemployment.

[20] Luna Greenstein, "Can Stigma Prevent Employment," *National Alliance on Mental Illness*, October 16, 2017, https://www.nami.org/Blogs/NAMI-Blog/October-2017/Can-Stigma-Prevent-Employment#:~:text=The%20short%20answer%20is%20yes,for%20their%20behavior%20and%20symptoms.
[21] Evelien P. Brouwers, "Social stigma is an underestimated contributing factor to unemployment in people with mental illness or mental health issues: position paper and future directions." *BMC psychology* 8 (2020): 1-7; National Association for Mental Illness, "Mental Illness: NAMI Report Deplores 80 Percent Unemployment Rate; State Rates and Ranks Listed—Model Legislation Proposed," *National Association for Mental Illness*, January 1, 2014, https://www.nami.org/Press-Media/Press-Releases/2014/Mental-Illness-NAMI-Report-Deplores-80-Percent-Un#:~:text=%E2%80%94One%20of%20the%20best%20steps,on%20Mental%20Illness%20(NAMI).
[22] Substance Abuse and Mental Health Services Administration, "Behavioral Health Barometer: New York, Volume 4," *Department of Health and Human Services*, 2015, https://www.samhsa.gov/data/sites/default/files/NewYork_BHBarometer_Volume_4.pdf.
[23]David Mechanic, Scott Bilder, and Donna D. McAlpine, "Employing Persons with Serious Mental Illness," *Health Affairs*, 21, no. 5 (2002): 242-253, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.21.5.242?casa_token=Xo8FlMj_mR8AAAAA:KOX8rTmtDp0e-CDWZpBEXVcBakCZ0ku3wf4NRgXKA-ArOpeTKiiLVgOcZI8F4Yo83iobhPUwTDk.
[24] Mechanic, *et al.*
[25] Mechanic, *et al.*, 252 ("Many employers are reluctant to hire persons with a history of mental illness because of their concern about unpredictable performance, work absenteeism, and possible disruptions in the workplace."); Brouwers, "Position Paper," *supra* note xx, at 5–6 (finding that "stigma is likely to lead to adverse job outcomes" for individuals with both mild and severe mental health concerns).
[26]Nene Ernest Khalema and Janki Shankar. "Perspectives on employment integration, mental illness and disability, and workplace health." *Advances in Public Health* 2014 (2014), https://www.hindawi.com/journals/aph/2014/258614/.
[27] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: New York, 2015.
David Mechanic, Scott Bilder & Donna D. McAlpine, *Employing Persons with Serious Mental Illness* 246 (2002).
[28] Brouwers, "Position Paper."
[29] Khalema and Shankar, "Perspectives."
[30] Brouwers, "Position Paper."
[31] Katherine Ponte, "People with mental illness can work," *National Alliance on Mental Illness*, October 21, 2019, https://www.nami.org/Blogs/NAMI-Blog/October-2019/People-with-Mental-Illness-Can-Work.
[32]Nan Roman, "Nan Roman's Keynote Address from the 2020 Solutions for Individual Homeless Adults Conference," *National Alliance to End Homelessness*, February 25, 2020, https://endhomelessness.org/nan-romans-keynote-address-from-the-2020-solutions-for-individual-homeless-adults-conference/; Johnson and Levine, "Homelessness."
[33] The Network, "Reinvest, Recover, Revitalize: Supportive Housing Solutions for a Better New York," *The Network: Supporting Housing Network of NY*, https://shnny.org/images/uploads/PolicyPlatformREV7-compressed.pdf.
[34] Matthew Haag, "'She Wants Well-Qualified People': 88 Landlords Accused of Housing Bias," *The New York Times*, March 15, 2021, https://www.nytimes.com/2021/03/15/nyregion/real-estate-lawsuit-section-8-discrimination.html?searchResultPosition=1.
[35] https://fhcnyc.org/family-homelessness-coalition-responds-to-city-council-voting-yes-on-intro-146/.

The Tremendous Value and Vital Importance
of Council Member Joseph's Res 0583-2023

Testimony on the Mental Health Roadmap Legislative Package
for New York City Council Committee on Mental Health, Disabilities and Addiction

Linda Lee (Chair) Chair
Tuesday, May 4, 2023
by
Thelma Dye, PhD, The Hilde Mosse Executive Director and CEO and
Paula Magnus, Deputy Director
Northside Center for Child Development, Inc.
Northside Center for Child Development Day School

All of us at Northside are grateful to Chairperson Lee, as well as Council Members and their staffs on the Committee on Mental Health, Disabilities and Addiction for conducting this hearing on the Mental Health Roadmap Legislative Package. We greatly appreciate all the hard work the Committee is doing to protect the City's children and thank all of you for these continuing efforts. **While we support all of the Resolutions your committee will consider in today's hearing, this testimony will address only Council Member Joseph's Res 0583-2023 and Council Member Shulman's Res 0592-2023.**

So you know who we are, we've supplied background information about Northside and our longstanding relationship with the City Council on the last page of this document, after the written testimony.

I. **Our Testimony in Support of Council Member Shulman's Res 0592-2023 calling on New York State and the 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.**

We believe the facts stated in the Whereas clauses in the legislative text of **Res 0592-2023** definitely demonstrate that low Medicaid reimbursement rates are the central cause of the gross neglect of the mental health of the thousands of New York State residents on Medicaid. We also note that low Medicaid reimbursement rates also radically threaten the solvency and existence of Article 31 Outpatient Clinics. This affects all residents of New York City and State and our economies. In a document titled, "**U.S. Surgeon General Releases New Framework for Mental Health & Well-Being in the Workplace**, Surgeon General Dr. Vivek Murthy stated, **"A healthy workforce is the foundation for thriving organizations and healthier communities."**[1] Where the Resolution's legislative text states that "*Medicaid reimburses provider 57% percent of the amount Medicare does for the same service*," we fear that some may view that as a 43% savings, but

[1] https://www.hhs.gov/about/news/2022/10/20/us-surgeon-general-releases-new-framework-mental-health-well-being-workplace.html

following the Surgeon General's point, that "savings" is a false economy because **it leaves thousands of low and moderate income New Yorkers suffering untreated mental illness for their whole lives and reducing if not eliminating their contributions to the City and the State's economy.** There is no moral or economic justification for leaving Medicaid Reimbursement Rates below what market conditions and the well being of thousands of New Yorkers requires.

II. **Our Testimony in Support of Council Member Joseph's Res 0583-2023 calling "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."**

At present, Northside's clinical staff has five vacant positions and as that number suggests, based on the salaries we can offer, (based on our Medicaid Reimbursement Rates) Northside's Clients' demand for mental health professionals greatly exceeds the supply. This shortage of mental health professionals is occurring here in the City and Nationwide - - during a local and national mental health crisis.

In February 2023 the Centers for Disease Control and Prevention reported that **in 2021, nearly 1 in 3 high school girls reported that they seriously considered suicide — up nearly 60 percent from a decade ago**.[2] Also alarmingly, the report stated, "Across almost all measures of substance use, experiences of violence, mental health, and suicidal thoughts and behaviors, female students are faring more poorly than male students. These differences, and the rates at which female students are reporting such negative experiences, are stark." But the report also stated that our country's mental health afflicts, "**nearly all groups of students**," and that the "percentages of students **who seriously considered suicide, made a suicide plan, or attempted suicide were high and have increased**."[3]

Recovery.org published an article by Kerry Nenn which stated, "Our nation is experiencing a dangerous imbalance. The National Council for Behavioral Health reports that **77 percent of counties across the country have severe shortages of behavioral health professionals.** Many who desperately need support are being left out in the cold. For instance, residents of Chicago who need counseling may wait a year or more before they see a specialist. **A Harvard University study recently found just 17 percent of phone calls placed to get an appointment with a mental health counselor were successful**."[4]

---

[2] Youth Risk Behavior Survey Data Summary & Trends Report: 2011-2021 (cdc.gov) at: https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf

[3] Ibid

[4] https://recovery.org/were-facing-a-shortage-of-mental-health-professionals/

In an article titled, "**A growing psychiatrist shortage and an enormous demand for mental health services**" the Association of American Medical Colleges quoted Saul Levin, MD of the American Psychiatric Association saying, "**People can't get care. It affects their lives, their ability to work, to socialize, or even to get out of bed**."[5]

The Demand for Mental Health Services is Increasing Sharply and Will Continue to do so. Fortune Business Insights reports, "**The U.S. behavioral health market is projected to grow** from **$79.69 billion in 2022 to $105.14 billion by 2029**, at a CAGR {Compound Annual Growth Rate} of 4.0% in forecast period, 2022-2029, exhibiting a CAGR of 4.0% during the forecast period. The global Covid-19 pandemic has been unprecedented and staggering, **with behavioral health services experiencing higher than anticipated demand across the U.S. compared to pre-pandemic levels**."[6]

Given that Northside's Article 31 Outpatient Mental Health Clinic is at 1475 Park Avenue and the corner of East 108th Street, in the heart of East Harlem, to serve our Black and LatinX clients optimally, we try to fill some of our Professional Mental Health with Black and LatinX staff. Working with these applicants and employees, we've learned that many of them are the first in their families to achieve graduate degrees and or professional licensing and that they must support their own immediate and extended family members. As such, **the high cost of their education in the mental health field, combined with the low pay (due to low Medicaid reimbursement rates for the services they provide) are enormous disincentives to go into and stay in the mental health profession.** Thus, Northside and our peer Agencies in the City that serve a predominantly Black and LatinX client base cannot optimally meet their client's mental health needs.

For all of the above stated reasons, we urge the City to act on Resolution **0583-2023** to create a formal pipeline including so agencies like Northside can find staff available to provide mental health services to the at-risk children we serve.

Northside also strongly supports all of the other Introductions and Resolutions your Committee is considering. We are confident that if the City Can act on these Resolutions, it will benefit and protect the City's most at risk children and families.

We thank Chairperson Lee and the whole Committee on Mental Health, Disabilities and Addiction and its staff members for conducting the hearing and for considering this testimony.

---

[5] https://www.aamc.org/news-insights/growing-psychiatrist-shortage-enormous-demand-mental-health-services#:~:text=Several%20factors%20fuel%20the%20shortage,Washington%20(UW)%20in%20Seattle.

[6] https://www.fortunebusinessinsights.com/u-s-behavioral-health-market-105298

About Northside:

Northside Center for Child Development, Inc. ("Northside") was founded in 1946 by Drs. Kenneth & Mamie Phipps Clark, whose groundbreaking research, the Black/White Doll Test, was the first-ever social science research submitted as hard evidence in the Supreme Court's history and provided the factual basis for the "Brown v. Board of Education" (1954) decision which declared segregation in public schools an unconstitutional deprivation of equal protection under the 14th Amendment.

Northside is a 77 year old Article 31 Outpatient Mental Health Clinic that provides youth and their families with psychiatric, psychopharmacological, and psychotherapy services. Clinical staff is trained in evidence-based treatment models including Cognitive Behavior Therapy, COPE, Knowledge Empowers You (KEY), and Power Source. The clinic provides Individual and Family Therapy, Home Based Crisis Intervention, a Special Needs Unit, Early Childhood Mental Health, Project Care, Family Connections, and Youth Groups. In addition, Northside has clinicians in 15 New York City Schools. The clinic also runs Head Start/Early Head Start locations at 302-306 East 111th Street, New York, N.Y. 10029, 25 Chapel Street, Brooklyn, N.Y. 11201 and 745 Eagle Avenue, Bronx, N.Y. 10455. Northside also operates Northside Center for Child Development Day School. The Clinic and the School provide high-quality psycho-educational services to 2,500 children a year.

The City Council has been funding Northside's popular After School and Summer Program for decades. The Council funded Capital Improvements so, in May 2021, Northside Center for Child Development, Inc and its affiliate, Northside Center for Child Development Day School could move into their new 28,300 square foot headquarters at 1475 Park Avenue, New York, New York, 10029. For the last several years, the Council has also funded Northside's Court Involved Youth Initiative and Northside's Children Under Five Initiative.

Casey Dalporto
Senior Policy Attorney
New York County Defender Services

Before the
New York City Council
Committee on Mental Health, Disabilities and Addiction

Hearing on Mental Health Roadmap

May 4, 2023

My name is Casey Dalporto and I am the Senior Policy Attorney at New York County Defender Services (NYCDS). We are a public defender office that provides high-level trial advocacy and social work support for thousands of indigent people facing criminal allegations in Manhattan courts every year. We also advocate for systemic reforms that provide meaningful and positive change for our client communities throughout New York City.

NYCDS strongly supports the Council's Mental Health Roadmap, including the legislative items on today's agenda. We thank Speaker Adams, Chair Lee, and the other members of this committee who have worked diligently to put together a document that, if adopted, would fundamentally improve how New York supports individuals and families dealing with the complexities of mental health concerns.

In particular, as a founding member of the Treatment Not Jail Coalition, which advocates for increased investment in community-based mental health treatment and passage of the Treatment Not Jail Act, we call on the Council to pass Reso. 156 calling on the State to pass the bill this legislative session. We thank you for your time and attention to this critical issue.

I. The New York City Council Should Pass Reso. 156 in Support of the Treatment Not Jail Act (S.1976A-Ramos/A.1263A-Forrest)

Any plan to address the mental health crisis plaguing our city must recognize the deep entrenchment of those with mental health issues in our criminal legal system. To be clear, psychiatric diagnoses are medical diagnoses. Yet too often, our state relies on law enforcement and the criminal legal system - rather than our healthcare system - to address individuals in mental health crisis. Thus, those with mental health conditions are over-policed and their mental health issues are often criminalized.

Indeed, people with mental health conditions are overrepresented in New York City's carceral system. More than half (52%) of the people in New York City's Department of Correction custody are recommended for mental health services, and in 2020, an average of 17% of incarcerated people were diagnosed with a debilitating "serious mental illness" such as schizophrenia, schizoaffective disorder and bipolar disorder.[1] In some facilities, the number of people with mental health diagnoses exceed those without.[2] New York State's jails and prisons have become larger mental health providers than psychiatric hospitals.[3] In fact, Rikers Island in New York City houses more people with mental illness than any psychiatric hospital in the entire country.[4] Importantly, New York's carceral system is inadequately equipped to provide mental health or psychiatric treatment leading to a rise of avoidable deaths and systemic failures to protect incarcerated people with mental illness. The unprecedented number of deaths at Rikers Island in recent years is an ugly reminder of this.[5]

Unfortunately, as discussed below in subsection (c), thousands of justice-involved New Yorkers who become entangled in the criminal legal system due to their mental health or substance dependence health condition have few opportunities to exit the revolving door of incarceration and criminalization. Our criminal legal system's failure to afford treatment as opposed to incarceration continues the vicious cycle of destabilization and trauma, increase the chance of recidivism, and ultimately fails to protect our communities.

Thus, while we fight for a day when our police and our criminal legal system stop serving as the default response for those in mental health crisis, in the meantime we must provide legal off-ramps—like those that would be created through Treatment Not Jail—for New Yorkers trapped in this dragnet.

a. Increasing Incarceration Leads to More Recidivism and Decreased Public Safety

In our office, we see far too many human beings sent to jail or prison when all they really need is treatment. After their sentences, they emerge from jail or prison far less stable than when they entered. It is not surprising to find these same clients rearrested after serving their sentences, often for more serious charges. This kind of revolving door recidivism - which often includes continual, ineffective, and costly inpatient psychiatric admissions - harms not only these individuals, but our society as a whole.

Meanwhile, our reliance on incarceration has made our communities less safe. A robust body of research analyzing the impact of incarceration in New York and nationwide indicates that imprisoning those entangled in the criminal legal system makes people *more likely* to re-offend.[6]

---

[1] New York City Comptroller. (March 2021). FY 2022 Agency Watch List: Department of Correction. Available at: https:// comptroller.nyc.gov/wp-content/uploads/documents/Watch_ List_DOC_FY2022.pdf

[2]Source: Vera Institute of Justice.

[3] https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness.

[4] Serious Mental Illness Prevalence in Jails and Prisons - Treatment Advocacy Center

[5] Jonah E. Bromwich, The New York Times, *Medical Care at Rikers is Delayed for Thousands, Records Show* (February 1, 2022), https://nytimes.com/2022/02/01/nyregion/rikers-island-medical-care.html .

[6]Cullen, F. T., Jonson, C. L., & Nagin, D. S. (2011). Prisons Do Not Reduce Recidivism: The High Cost of Ignoring Science. The Prison Journal, 91(3_suppl), 48S-65S. https://doi.org/10.1177/0032885511415224; Stemon, D. (2017, July)."The Prison Paradox: More Incarceration Will Not Make Us Safer." Vera Institute. Retrieved January 2022, from https://www.vera.org/downloads/publications/for-the-record-prison-paradox_02.pdf; Emily Leslie & Nolan Pope, The

Jail and prison are inherently traumatizing and destabilizing environments. Disconnected from any community supports, individuals in jails and prisons are left to languish with inadequate mental health treatment, and surrounded by chaos, violence, and widespread drug use. Moreover, once their period of incarceration ends, these newly traumatized and further destabilized individuals leave prison and jail with new mental health conditions due to their experiences. They are then expected to secure stable housing, employment, health insurance, medical and mental health care on their own while navigating the myriad adverse collateral consequences of having a criminal conviction. [7] Unsurprisingly, the risks for substance use, untreated mental health conditions, and ultimately, re-arrest – often for more serious charges – result. This fails individuals and all of us both: neither public health nor public safety is served by this.

b. Judicial Diversion Makes Individuals and Communities Safer

The prevailing data and research demonstrate that judicial diversion (AKA "treatment court") is effective, less costly, and improves both public health and safety.

Individuals who apply to participate in treatment courts are rigorously assessed by clinical teams that delve into the person's psychosocial and psychiatric history. The team of mental health practitioners then produces a written report informing the presiding judge whether there is a treatable condition that played a role in the applicant's criminal charges. The judge must then decide whether it is in the interest of public safety for this individual to receive a treatment-based disposition. If the judge agrees, clinicians devise a multi-phase treatment plan. Participants in treatment courts must return to court frequently (often more than criminal defendants in non-diversion courtrooms) to discuss their progress. The court provides continuous monitoring of each participant, with ongoing input from the clinical team and ample opportunities for the defense and prosecuting attorneys to be heard off-calendar and at court appearances. If a participant is struggling, then they will not be advanced to the next phase, and can be sanctioned. People mandated into one of the state's 39 *ad hoc* mental courts can resolve the criminal case without incarceration, and often without sustaining a criminal conviction. On average, participants spend between 1-2 years in treatment courts before completing their mandate. They graduate to applause with supportive housing and long-term treatment in place. They often rekindle fractured relationships with family members and friends. Many graduates who once feared entering courthouses come back to visit the judge and treatment court team who changed their lives. It is no surprise that treatment court graduates are proven to have a significantly lower rate of recidivism.[8]

Unintended Impact of Pretrial Detention on Case Outcomes: Evidence from New York City Arraignments 60 J. OF L. AND ECON. 3, 529-557 (2017), www.econweb.umd.edu/~pope/pretrial_paper.pdf; Will Dobbie et al., The Effects of Pre-Trial Detention on Conviction, Future Crime, and Employment: Evidence from Randomly Assigned Judges (Nat'l. Bureau of Econ. Research, Working Paper No. N22511, 2018), www.nber.org/papers/w22511.pdf.

[7] Christopher Lowenkamp et al., The Hidden Costs of Pretrial Detention, THE LAURA AND JOHN ARNOLD FOUND., https://craftmediabucket.s3.amazonaws.com/uploads/PDFs/LJAF_Report_hidden-costs_FNL.pdf; Baer et al. Understanding the Challenges of Prisoner Reentry: Research Findings from the Urban Institute's Prisoner Reentry Portfolio, Urban Institute Justice Policy Center (January 2006), https://www.urban.org/sites/default/files/publication/42981/411289-Understanding-the-Challenges-of-Prisoner-Reentry.PDF;

[8] Michael Mueller-Smith & Kevin T. Schnepel, Diversion in the Criminal Justice System, 8 THE REV. OF ECON. STUD. 2, 883–936 (2021), https://doi.org/10.1093/restud/rdaa030 (finding that diversion cuts reoffending rates in half and grows quarterly employment rates by nearly 50% over 10 years); Amanda Agan, Jennifer Doleac & Anna

Diversion is also proven to be significantly more cost-efficient than incarceration. While New York City spends $556,539 per year to incarcerate just one person in its jail system, the New York State Office of Court Administration reports that every $1 invested in treatment courts yields $2.21 in savings.[9] Investing in mental health courts, community treatment and housing is a far more cost-effective use of state resources than incarceration.[10]

Moreover, the use of treatment courts are popular. They receive support from both Democrats and Republicans[11]. They are favored by members of the public[12] and importantly, by the overwhelming majority of crime victim survivors.[13]

c. Judicial Diversion Programs Protect Public Safety and Increase Public Health, But They Are Underutilized and Need Expansion and Improvement

We all care about public safety, no matter our race, ethnicity, gender-identity, socioeconomic status, geographic location, or political persuasion. However, if we are going to improve public safety with respect to those who become entrenched in the criminal legal system, then we must amend the existing Judicial Diversion statute to expand access to treatment courts for those with underlying mental health challenges, and improve the existing diversion court model to accord with proven-effective best practices.

Despite the widespread support of treatment courts, their cost-effectiveness and their efficacy at reducing crime, they are woefully underutilized in New York State. On February 7, 2023, Acting State Chief Administrative Judge Tamika Amaker testified at the New York State Legislature Public Safety Budget hearing that there has been a decline in the usage of problem-solving courts. The reasons for this are clear to those of us who practice in this field: there is presently no statute delineating judicial diversion for people with mental health disorders, or with cognitive or intellectual disabilities. Indeed, mental health treatment courts are not available in every county in

---

Harvey, Misdemeanor Prosecution (Nat'l Bureau of Econ. Res., Working Paper No. 28600, 2021), https://www.nber.org/system/files/working_papers/w28600/w28600.pdf (finding non-prosecution of a nonviolent misdemeanor offense leads to large reductions in the likelihood of a new criminal complaint over the next two years); David Huizinga & Kimberly L. Henry, The Effect of Arrest and Justice System Sanctions on Subsequent Behavior: Findings from Longitudinal and Other Studies, in, THE LONG VIEW ON CRIME: A SYNTHESIS OF LONGITUDINAL RESEARCH 244 (Akiva M. Liberman, ed., 2008); John Laub & Robert Sampson, Life-Course and Developmental Criminology: Looking Back, Moving Forward, J. OF DEV. AND LIFE-COURSE CRIMINOLOGY (2020); Shelli B. Rossman, Janeen Buck Willison, Kamala Mallik-Kane, KiDeuk Kim, Sara Debus Sherrill, P. Mitchell Downey, Criminal Justice Interventions for Offenders with Mental Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn, New York, Nat'l Inst. of Justice (April 2012), https://www.ojp.gov/pdffiles1/nij/grants/238264.pdf.

[9]New York State Unified Court System, The Future of Drug Courts in New York State: A Strategic Plan (2017), https://www.nycourts.gov/legacyPDFS/courts/problem_solving/drugcourts/The-Future-of-Drug-Courts-in-NY-State-A-Strategic-Plan.pdf.

[10] What Caused the Crime Decline? | Brennan Center for Justice (2015)

[11] United States Republican Party Committee, Bipartisan Safer Communities Act, Sept. 2022, https://www.rpc.senate.gov/policy-papers/the-bipartisan-communities-acts-treatment-court-funding .

[12] National Center for State Courts, State of the State Courts: 2022 Poll, The Bipartisan Safer Communities Act's Treatment Court Funding (senate.gov).

[13] Alliance for Safety and Justice, Crime Survivors Speak: National Survey of Victim's Views on Safety and Justice, 2022, Crime Survivors Speak Report.pdf (allianceforsafetyandjustice.org).

New York and many of the *ad hoc* mental health courts that do exist rely on outdated approaches to treatment and eligibility.

The Treatment Not Jail Act will open access to treatment courts and improve success rates by building out and significantly expanding our existing Judicial Diversion statute. Criminal Procedure Law 216, originally passed in 2009, is currently the only law that permits judges, independent of the prosecutor, to offer court-mandated treatment to people with substance use disorders as an alternative to incarceration. In the fourteen years since its enactment, there have been very few amendments to reflect the evolution of treatment modalities or updates in diversion court best practices, and it has become evident that the current law requires modernization.

First and most obviously, currently Criminal Procured Law 216 limits eligibility to people with underlying substance use or alcoholism disorders. Our statutory drug courts often reject people with serious mental health conditions or intellectual or developmental disabilities because "substance use" is not the primary diagnosis.

Despite our current mental health crisis, the vast majority of justice-involved people with underlying serious mental health issues are often excluded from any treatment court opportunities, and instead are sent to jail or prison, where upon their release, they are without supports, without health care, and without a home – again, all of which can lead to drug use, psychiatric decompensation and ultimately, re-offending.

In the absence of statutory authority permitting treatment courts for those with underlying mental health issues, some District Attorney offices and Courts throughout the state created *ad hoc* mental health courts. However, access to these courts remains unevenly and minimally applied. In some instances, this is because prosecutors have gatekeeping power to exclude whomever they wish, and in counties where there is a lack of extensive mental health training for their district attorney offices, this results in routine denial of treatment in favor of incarceration. In addition to rejecting mental health court applicants due to the person's criminal history or underlying charges, people diagnosed only with intellectual disabilities, developmental disabilities, traumatic brain injuries, neurological disorders and personality disorders - even when the criminal charges are directly related to their disability or impairment – are also not generally accepted.

Even in New York County, where our organization staffs a Mental Health Attorney Specialist to help those with underlying mental health issues navigate the criminal legal system and access treatment, and highly trained Mental Health and Alternatives To Incarceration Assistant District Attorneys working in the Pathways to Justice Unit are eager to divert clients with psychiatric and substance use diagnoses from prison and jail, our mental health courts cannot reach everyone in-need due to the strict cap on the number of cases admitted per year (currently 50).

As a result, the participation rates in such makeshift courts are abysmal. In 2021, there were only 36 mental health courts across the state serving only 570 participants. In other words: out of the 274,592 adults arrested in 2021, only 570 people were able to participate in mental health courts.

Moreover, as there is no statewide statutory authority ensuring uniform (or even any) due process, whether or not a person is considered, accepted or maintained in these ad hoc mental health courts

in New York is too often a matter of being lucky enough to be in a county that chooses to follow treatment court best practices and scientific developments, or unlucky to have mental illness and be charged with a crime in a county that does not.

The result is that many of our fellow New Yorkers are sent to jail or prison and eventually released back into their communities without a home, without supports and without health care. This does not protect public safety.

d. The Treatment Not Jail Act (S.1976A-Ramos/A.1263A-Forrest) Would Expand Access to Treatment Courts for Those with Underlying Mental Health Challenges

The Treatment Not Jail Act (S.1976A-Ramos/A.1263A-Forrest) creates meaningful off-ramps from the carceral system, while increasing opportunities for robust community-based substance use and mental health care services for those who need them, and for strong communities that keep everyone safe.

The Treatment Not Jail Act would expand existing Criminal Procedure Law 216 to permit treatment courts to accept people with mental health diagnoses, intellectual disabilities and other disorders that impair their functioning in society and leads to criminal legal system involvement - not only people with a substance or alcohol dependence.

The bill also evolves Article 216 to empower Judges with the discretion to order court ordered diversion for any criminal charge after clinical assessment, and when there are medical bases for doing so. Expanding diversion opportunities will ensure that people who most in need receive treatment, and will also streamline the assessment process.

The Treatment Not Jail Act would further remedy inequitable outcomes[14] by allowing a judge, informed by clinical assessments, to subsequently dismiss or reduce a participant's charges without the requirement of an up-front plea. This would protect people from the collateral consequences of a conviction that would have been vacated anyway upon completion of the treatment mandate. These dire consequences include barriers to employment, licensing, housing, education and immigration—all of which foster instability and ultimately recidivism.[15] A pre-plea model also removes the coercive aspects of our legal system and addresses the reality that poor people, particularly those who are Black and Brown, too often plead guilty to crimes they did not commit in order to get out of jail, access treatment, protect their jobs, keep their housing, maintain their schooling, return to their loved ones, and avoid the disruption to their lives of having to return to court repeatedly. It also avoids exclusion of those who are not guilty of all of the charges against them. This amendment to Criminal Procedure Law 216 would also presume treatment rather than

[14] For example, Syracuse County Treatment Court, a court that serves a majority white population, allows some individuals to participate pre-plea. Since participants must live in Onondaga County, the population of which is 80% white (as compared to the population of NYC, which is 42.7% white) we see a more open and accepting model benefitting the majority white residents in Onondaga County, whereas but a similar model has been rejected in other courts serving a majority of Black and Brown populations.

[15] https://niccc.nationalreentryresourcecenter.org/#:~:text=What%20are%20collateral%20consequences%3F,rights%2C%20benefits%2C%20and%20opportunities. For example, a conviction can affect employment requiring licensure in New York. The Department of State reviews criminal convictions and open cases when an individual applies for licensure. https://justiceandopportunity.org/wp-content/uploads/2020/05/License-Guides_Final.pdf

incarceration - mitigating racial and gendered disparities in carceral policies.[16] In addressing inequity, The Treatment Not Jail Act would ensure the even application throughout the state of what is already in use in New York.[17]

The Treatment Not Jail Act further evolves Article 216 by incorporating modern best practices of diversion courts and evidence-based scientific approaches to treatment. The bill guarantees due process protections for participants so they cannot be remanded summarily to jail without evidentiary findings. It follows social science best practices in adopting proven and effective harm reduction principles[18], rather than outdated punitive models which are demonstrated to disparately exacerbate harm to people with mental illness and substance use diagnoses.[19]

In essence, both the individual participants and our communities as a whole will be healthier and safer if we amend Article 216 of the Criminal Procedure Law and enact this legislation.

II. Other Mental Health Roadmap Proposed Legislation

NYCDS supports the Mental Health Roadmap Legislative Package that is before this Committee today. We will address each bill on the agenda individually.

a. Int. 1006-2023 (Bottcher) - 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

NYCDS supports this legislation to expand access to care by educating the public about existing city resources.

---

[16] In New York, per 100,000 people incarcerated: 1,655 are Black, 709 are American Indian/Alaska Native, 607 are Hispanic, 219 are white.https://www.prisonpolicy.org/profiles/NY.html; and 1,882 per 100,000 lesbian, gay, and bisexual people are incarcerated, compared with 612 per 100,000 U.S. residents aged 18 and older. https://www.prisonpolicy.org/blog/2021/03/02/lgbtq/. In both prisons and jails, lesbian or bisexual women are sentenced to longer periods of incarceration than straight women. Gay and bisexual men are more likely than straight men to have sentences longer than 10 years in prison. https://www.prisonpolicy.org/blog/2021/03/02/lgbtq/.

[17] The more recent Manhattan Misdemeanor Mental Health Court is structured with a pre-plea model.

[18] This will reduce dangerous overdose and death related to substance use as "cold turkey" approaches to treating substance use are widely viewed as dangerous and counterproductive to meaningful, autonomous, and safe recovery. Bourgon G., Guiterrez L. (2013) The Importance of Building Good Relationships in Community Corrections: Evidence, Theory and Practice of the Therapeutic Alliance. In: Ugwudike P., Raynor P. (eds) What Works in Offender Compliance. Palgrave Macmillan, London. Available at https://doi.org/10.1057/9781137019523_15; Horvath, A. (2015). Therapeutic/Working Alliance, available at https://doi.org/10.1002/9781118625392.wbecp262.; Blasko, B, Serran, G., Abracen, J. (2018), The Role of the Therapeutic Alliance in Offender Therapy: The Translation of Evidence-Based Practices to Correctional Settings. In New Frontiers in Offender Treatment.

[19] https://www.researchgate.net/publication/329010560_The_Role_of_the_Therapeutic_Alliance_in_Offender_Therapy_The_Translation_of_Evidence-Based_Practices_to_Correctional_Settings; Cournoyer, L., Brochu, S., Bergeron, J. (2007). Therapeutic alliance, patient behaviour and dropout in a drug rehabilitation programme: the moderating effect of clinical subpopulations. Available at https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1360-0443.2007.02027.

b. Int. 1018 (Lee) - A Local Law to amend the administrative code of the city of New York, in relation to reporting on involuntary removals

NYCDS strongly rejects Mayor Adams' 2022 proposal to grant police the authority to involuntarily remove people and order them to a hospital. The data is clear: involuntary hospitalization is traumatizing and can be extremely harmful to a person's recovery. People are best poised to succeed in their recovery goals when treatment is voluntary, supportive and not coercive. However, we believe that the Council can play an important oversight role in helping to stem any human or civil rights violations that may occur as the Mayor's policy is implemented. To that end, we support this bill to require relevant agencies to report critical information about the implementation of the Mayor's plan.

c. Int. 1019 (Lee) - 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

NYCDS strongly supports this bill. Our forensic social workers spend hours looking for mental health resources for our clients. This is a challenge as information is frequently changing, with staff turnover and hours and locations changing. It is crucial that city agencies create a central repository for this information so that professionals and members of the public alike are able to access this crucial information. That being said, it cannot be a one and done task. The department should be required to update information on a regular basis, perhaps monthly or quarterly, to ensure that New Yorkers don't waste their time trying to track down resources listed on the database that are no longer available.

d. Int. 1021 (Powers) - A Local Law to amend the administrative code of the city of New York, in relation to crisis respite centers

NYCDS applauds the Councilmember for introducing this bill and urges the Council to enact it immediately. NYCDS and our sister defender organizations have been advocating for expanded access to crisis respite centers for nearly a decade. Crisis respite centers are a crucial tool to help eliminate unnecessary arrests and connect people with the tools they need in crisis. Every day we see people come into the criminal legal system after a confrontation with family members because of challenges related to mental illness. New Yorkers need and deserve a one-stop-shop to access mental health support that is not a hospital far from their home and community. We need to have crisis respite centers in every neighborhood, serving youth and adults of all ages. These centers can also provide a crucial safety valve in times of family crisis, to eliminate the possibility of intra-family violence and give people a safe space to cool off from one another. We would urge the Council to pass the bill in its limited form right now (creating two crisis respite centers in each borough) and expand it in the years to come so that no one has to travel far to get the emergency mental health care and support that they need.

e. Int. 1022 (Riley) - A Local Law in relation to a pilot program establishing community centers for individuals with severe mental illness in high-need areas

NYCDS applauds the Councilmember for introducing this bill and urges the Council to enact it immediately. As with Int. 1021, we have been urging for the creating of community centers or clubhouses like Fountain House to support people living with mental illness in their recovery. We urge the Council to work with Fountain House and other clubhouse models to bring this crucial tool to our most high-need communities. New York must invest in a broad continuum of care for the diversity of mental health needs of our communities. Community centers or clubhouses are a critical component of that infrastructure. As with Int. 1022, we urge passage of this pilot bill in hopes that it can soon be instituted in all of our communities, not just a small few.

f. Res. 88 (Holden) - 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.

NYCDS generally supports legislation to expand access to federal Medicaid funding, but are unable to comment on the specifics of this federal legislation.

g. Res. 583-2023 (Joseph) - 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.

NYCDS stands with NAMI-NYS in calling for the state to subsidize the education and licensing costs of CUNY students who work in public sector mental health professions. It is a real challenge for us to get our clients into lifesaving mental health and substance use disorder programs because of staffing shortages statewide. The City and State must utilize all available tools to shore up this crucial workforce as quickly as possible, including not only subsidized education and loan repayment assistance, but also by paying workers middle class wages so that they can afford to only work one job and take care of their families.

h. Res. 584 (Lee) - 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.

NYCDS generally supports legislation to expand access to healthcare for our clients, but are unable to comment on the specifics of this legislation.

i. Res. 587 (Powers) - 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.

NYCDS generally supports legislation to expand access to healthcare but are unable to comment on the specifics of this legislation.

j. Res. 588 (Powers) - 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.

NYCDS strongly supports any efforts to expand access to supportive housing in NYC and across NYS. All roads lead to housing. Safe and affordable housing is the key to ending the revolving door of incarceration and creating a safe place to engage in the recovery process. We need more high-quality housing without barriers to people with complex needs and/or criminal convictions or pending criminal cases.

k. Res. 589 (Powers) - 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.

NYCDS has no official opinion on this resolution.

l. Res. 592 (Schulman) - 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.

NYCDS generally supports legislation to expand access to healthcare for our clients but are unable to comment on the specifics of this legislation.

III. Conclusion

The Treatment Not Jail Act (S.1976A, A.1263) recognizes that public health and public safety are intertwined and that healthy people make for strong communities that keep everyone safe. Treatment Not Jail could not come at a more opportune time as our state faces an unprecedented mental health crisis. The bill understands that most people who enter the criminal legal system are often victims of lifelong racial, gender-identity discrimination and economic injustice, including systemic failures resulting in a lack of access to health care, stable housing, and education. In the treatment court model proposed here, there is no "othering" but rather recognition of a participant's humanity and status as a community member. They are given the chance to get well and thrive in our shared community. Graduates of court-mandated treatment programs will emerge from the legal system without a criminal conviction or sentence of incarceration. They will be spared from the inevitable stigma and trauma that would otherwise have thwarted their ability to obtain stable housing, employment, and proper mental health and medical care. As a result, our communities will benefit and flourish and be healthier and safer.

We have a moral obligation and a practical imperative to reimagine our diversion court practices in the face of a changing public health, legal and scientific landscape. I urge the New York City Council to Pass Reso. 156 in support of state legislation, the Treatment Not Jail Act.

If you have any questions about my written or oral testimony, you can email me at cdalporto@nycds.org.

PROJECT GUARDIANSHIP
Changing the way we care for people.

Testimony for the NYC Council
Council Committee on Mental Health, Disabilities, and Addiction,
Chair Linda Lee
May 4, 2023

Presented by Kimberly George, President and CEO, Project Guardianship

Thank you, Chair Lee and Committee Members, for the opportunity to testify today. My name is Kimberly George, President and CEO of Project Guardianship, a nonprofit organization founded in 2005 by the Vera Institute of Justice, and which in 2020, became an independent entity providing comprehensive, court appointed guardianship services to hundreds of limited capacity New Yorkers citywide. We serve clients regardless of their ability to pay and provide services for some of the most compelling and complex cases in the city. We also share research and recommendations for building a better guardianship system and advocate for a more equitable service response for people in need of decision-making supports and/or protective arrangements.

Over the course of the past three years, we have witnessed firsthand that already marginalized communities have borne the brunt of COVID's devastation. We've seen increased rates of social isolation, Alzheimer's and related dementia diagnoses, homelessness, and substance use disorder, which experts have attributed to a mental health crisis gripping New York. On top of these unsettling trends, New York is also getting poorer. In fact, according to a recent NY Times article, fifty percent of New Yorkers cannot afford to live here: indeed, a *full half* of the city's households did not have enough money to comfortably hold down an apartment, access sufficient food and basic health care, and get around.[1] Our internal client data correlates these statistics: an overwhelming majority, 74%, of our clients live below the Federal Poverty Guidelines. Further, over half, 54%, have a diagnosed mental health disorder.

As the Council knows, in November 2022, Mayor Adams announced a plan to support more effective application of the City's standard for first responders to hospitalize individuals who appear too mentally ill to care for themselves, with or without their consent. Beyond additional training for police officers and others to evaluate whether a person needs to be taken to a hospital, little has been done to ensure improved outcomes, access to long-term care, or to limit rehospitalization. The police will be better trained to involuntarily commit struggling New Yorkers to hospitals, but much more is needed. Nothing was included in the plan to ensure that these individuals can access and secure the care, housing, and treatment they need to gain safety and stability. No infrastructure was put in place to ensure that they don't end up back on the street and subject to further police interaction or involuntary hospitalization.

Thankfully, the Council has stepped in and its leadership swiftly developed the *Mental Health Roadmap*. This comprehensive plan seeks to finally address the decades of disinvestment in, and

[1] https://www.nytimes.com/2023/04/25/nyregion/affordable-housing-nyc.html?smid=em-share

PROJECT GUARDIANSHIP
Changing the way we care for people.

disregard for, the mental health of New Yorkers and strives to advance their health, safety, and wellbeing. We were particularly pleased to see the expansion of prevention and supportive services as well as the reduction of criminal justice system interactions as key priorities of the plan. However, we would urge you to also include nonprofit guardianship services as a critical component of the Roadmap.

According to the NYS Office of Court Administration, 40% of guardianship petitions are filed by hospitals and other health providers. This occurs largely in cases where a patient cannot consent to services or arrange the financial components of a safe discharge and lacks familial support. Further, according to a report by the American Bar Association, mental illness is the reason for guardianship appointments in approximately 20 percent of cases nationwide.[2] Considering the data, we can expect an increase in guardianship petitions and appointments, and that – just like our hospitals – guardianship providers will also need more resources to meet that imminent need. Sometimes, guardianship is the only path towards safety and stability for New Yorkers deemed incapacitated due to mental illness; it can help prevent further crises, multiple rehospitalizations, and can help ensure that they receive the care they need to recover and lead healthy lives.

It is therefore critical that nonprofit guardianship services be included in the Mental Health Roadmap so that New Yorkers with serious mental health needs are protected and supported. Nonprofits also play a critical role in keeping people out of institutions by proactively connecting clients with a range of social, financial, and healthcare resources, efforts which save public dollars by limiting unnecessary Medicaid spending on avoidable hospitalizations while also stimulating local economies.

New York City must therefore create a dedicated funding stream to support guardians that provide care for individuals with serious mental illness, disabilities, and other complex health conditions. We urge the Council to include funding to support nonprofit guardianship in the FY24 budget. In doing so, more New Yorkers in need will be able to access the benefits and services to which they are entitled so they may live healthier lives.

Thank you again for the opportunity to testify today.

Please contact Kimberly George at kgeorge@nycourts.gov with any questions or requests for additional information.

[2] https://www.americanbar.org/groups/law_aging/publications/bifocal/vol_37/issue_3_april2016/new-york-state-guardianship-research/

Testimony before the New York City Council
Committee on Mental Health, Disabilities and Addiction
May 4, 2023

Doreen Thomann-Howe
Chief Operating Officer
Project Renewal

My name is Doreen Thomann-Howe, and I am the Chief Operating Officer at Project Renewal, a New York City homeless services nonprofit agency. Thank you for this opportunity to submit testimony.

For more than 55 years, Project Renewal has provided shelter, housing, health care, and employment services to hundreds of thousands of New Yorkers experiencing homelessness, with focus on those affected by mental illness, substance use, and criminal justice involvement. Thank you to Chair Lee and the entire City Council for your support of our programs.

Project Renewal is grateful for the Council's commitment to creating a comprehensive, responsive mental health system through its Mental Health Roadmap package and in its Preliminary Budget Response.

To ensure that we are investing in existing programs that work, funding and policy must go hand in hand. Project Renewal proudly operates a Support and Connection Center in East Harlem, and we are pleased that the Council has called for the expansion of this impactful model in every borough.

In partnership with the NYC Department of Health and Mental Hygiene, Project Renewal's Support and Connection Center provides stabilization and treatment services for adults experiencing mental health and/or substance use crises. It opened in 2020 as the first program of its kind in the city.

The Center's clients – whom we call "guests" – are referred by the NYPD as an alternative to arrest, summons, or the emergency room. Among our other referral sources are the Mayor's Subway Safety Task Force, the B-HEARD program, co-response teams, and OnPoint's Supervised Consumption Centers.

We serve up to 18 guests at a time, for stays of up to five days which can be extended to 10 days with permission from DOHMH. Guests have access to an interdisciplinary team of peer counselors and providers, including a psychiatrist and occupational therapist, in addition to meals, showers, and laundry. Our engagement is peer-led, and guests choose the services they receive, which is critical to building trust.

The Center fills a gap in the city's ecosystem of services for people experiencing homelessness, and acute mental health and substance use crises. We catch people who would otherwise fall through the cracks, provide them a safe space to access the services they need, and then connect them to longer term support.

We have now served over 800 New Yorkers at the Center. This January through March alone, as referral sources have increased, the Center has served 252 guests. Upon completion of their stay, over 50% of Center guests have chosen to stay engaged with our after-care services, which include connections to community services, long-term treatment, Safe Havens, and transitional

housing. The after-care services allow us to continue to build engagement and trust, and ultimately help guests to stay connected to the services they need.

In addition to the expansion of Support and Connection Centers, Project Renewal also supports other aspects of the Council's Mental Health Roadmap, including:

- **Intro 1019**, which would help us better understand the programs providing outpatient mental health services. It is currently very difficult for us to successfully refer clients for community-based mental health services due to waitlists. A database would help staff know which clinics have availability, particularly if it identifies open appointments.

- **Intro 1021**, which would ensure that each borough has at least two crisis respite centers. This would be a helpful resource, in tandem with the expansion of Support and Connection Centers.

The creation of a pilot for community centers where individuals with severe mental illnesses can access wraparound services and socialization (Intro 1022) could also be worth exploring. But resources may be better directed towards models like clubhouses and Support and Connection Centers, which have been shown to be effective.

We urge the Council to continue advocating for the expansion of Support and Connection Centers. Project Renewal is eager to collaborate with the Council to strengthen programs and bring providers, City agencies, and lawmakers together to fill longstanding gaps in our system and break down barriers to lifesaving care for New Yorkers with the greatest needs.

Thank you for this opportunity to testify.

The Samaritans of New York, Inc. (Suicide Prevention Center)
Testimony of Fiodhna O'Grady, Director of Government Relations to
The Committee on Mental Health, Disabilities and Addiction re.
Mental Health Roadmap Legislative Package
Thursday, May 4, 2023

Thank you, Chair Lee, for the opportunity to speak today.

I'm Fiodhna O'Grady and I am here speaking on behalf of The Samaritans of New York's suicide prevention center which for 40 years, has operated NYC's only anonymous and ***completely*** confidential suicide prevention hotline in addition to our public education and suicide loss bereavement programs.

First, I want to commend Chair Linda Lee, this Committee, Speaker Adams, and the Council especially those who sponsored many or the intro. Bills today for your work on this legislation.

Too often mental health initiatives are often proposed with lofty, but unspecific goals or. without commensurate funding; leaving our mental health infrastructure historically underfunded and incapable of meeting the mental health needs of New Yorkers. This plan is both specific and advocates for the requisite investment for it to succeed.

From the 1.5 million calls we have answered from New Yorkers in crisis we have learned that mental healthcare, crisis support, and suicide prevention are not one-size-fits-all.

People access help when they have choices they are comfortable with and services they trust that help them feel safe. We must provide these choices to people *before* they are in crisis, as well as when a person is *in the midst of a crisis*, and *after* the acute treatment phase has passed (SAMHSA 2020).

By explicitly tackling the workforce shortage; creating an accessible, centralized database for available mental health services; expanding access to respite centers and community centers for individuals with SMI; and funding existing, culturally competent, recovery-oriented CBO's this plan seeks to build out the continuum of care our city so desperately needs.

Samaritans' experience operating over 400 crisis centers in 40 countries has shown us that there is no singular solution. Rather, as this plan suggests, we need; as many varied and diverse options and viable alternatives available so that everyone can access care that helps them feel safe.

This is supported by research which found that "suicides can be reduced through a multilayered, overlapping approach" (Knox, 2010). The more touchpoints for support a person has, the more inclined they will be to seek help. The United States Air Forces Suicide Prevention Program, which utilizes this kind of multicomponent intervention model, was the single most effective program in the US.

At Samaritans, we recognize that our programs and services just one aspect of a larger network of mental health and social programs working together to improve the lives of those in crisis and ask, that in the age of 988, you continue to fund the only 100% anonymous confidential hotline as part of the safety net for New York's most vulnerable populations..

All New Yorkers deserve the same opportunity to make decisions about their health and well-being. Their voices should always be heard when plans like this are designed.

Samaritans is heartened by the Council's collaborative approach in creating The Roadmap. We are proud to be a partner alongside so many other community stakeholders who were given the opportunity to be that voice for the people we serve and to contribute expertise and experience during the developmental phase.

Finally, we have a renewed sense of hope that this will not just be a plan, but will become a real lifeline for those in crisis. To put it bluntly, you get what you pay for and it is clear that this Council is committed to investing in the wellbeing of every New Yorker.

Thank you for your time and for your continued support of Samaritans and other community-based programs that rely on the Council to provide essential services.

REFERENCES:

Knox K.L., Pflanz S., Talcott G.W., Campise R.L., Lavigne J.E., Bajorska A., Tu X., Caine E.D. The US Air Force Suicide Prevention Program: Implications for Public Health Policy. Am. J. Public Health. 2010;100:2457–2463. doi: 10.2105/AJPH.2009.159871.

Krishnamoorthy S, Mathieu S, Ross V, Armstrong G, Kõlves K. What Are Complex Interventions in Suicide Research? Definitions, Challenges, Opportunities, and the Way Forward. Int J Environ Res Public Health. 2022 Jul 14;19(14):8591. doi: 10.3390/ijerph19148591. PMID: 35886443; PMCID: PMC9315522.

Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic (CDC, 2020): https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm?s_cid=mm6932a1_w

National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (SAMHSA, 2020):https://www.samhsa.gov/sites/default/files/nationalguidelines-for-behavioral-health-crisis-care-02242020.pdf

the Network
Supportive Housing Network of NY

Testimony to NYC Council
Committee on Mental Health, Disabilities and Addiction
Mental Health Roadmap Hearing
Submitted by Supportive Housing Network of NY
May 4, 2023

Hello Chair Lee, and members of the New York City Council Mental Health, Disabilities and Addiction Committee. My name is Joelle Ballam-Schwan, and I am the Associate Director of Engagement and Communications at the Supportive Housing Network of NY. The Network is a statewide membership organization representing the nonprofit developers and operators of supportive housing, a proven affordable housing model with wraparound support services for individuals and families with a history of homelessness who face additional barriers to obtaining and maintaining housing on their own.

The Network would like to thank Speaker Adrienne Adams, Mental Health Committee Chair Linda Lee, Majority Leader Keith Powers, and the entire City Council for putting forward a holistic Mental Health Roadmap that calls for targeted investments in the historically underfunded mental health infrastructure and addresses the workforce crisis. This plan could not come at a more critical time. Fueled by years of neglect and historic underfunding across the mental health continuum and compounded by a global pandemic, New York's mental health and substance use challenges have reached crisis levels.

The Network would like to commend the Council for the following specific advocacy items in the roadmap regarding the City's FY24 budget: advocating for an additional $45 million for NYC 15/15, to meet the funding need for the plan's remaining supportive housing units, $12.8 million for funding for Justice-Involved Supportive Housing, as well as adequate funding for the expansion of DOHMH's Intensive Mobile Treatment Teams. All are desperately needed to further New York City's supportive housing, expand opportunities for those exiting incarceration, and serve New Yorkers with acute mental health needs.

We also want to thank the Council for including the need to reallocate NYC 15/15 in order to meet its production goals. NYC 15/15, a promise to create 15,000 units of supportive housing over 15 years, envisioned an even split between new development of congregate, single-site residences, and scattered site units rented on the private market with mobile case management services. Due to many difficulties with the scattered site model, seven years into NYC 15/15, only 17% of scattered site contracts have been awarded versus 70% of congregate awards. After further analysis by the Network, we urge the City to reallocate the remaining unawarded 6,295 scattered site units equally among following models:

1. Preservation of older congregate residences with little or no service funding. The City should dedicate a flexible preservation fund for services and operating, to pair with capital resources.
2. Traditional congregate sites, with nonprofits applying through normal channels via HPD and HRA.
3. Enhanced traditional scattered sites, with a service rate of $17,500 per unit, which matches congregate service rates.

4. Enhanced non-traditional scattered sites in city-funded affordable housing residences, with a service rate of $17,500 per unit, which matches congregate service rates.

The roadmap includes material solutions for addressing the shrinking workforce whose members deserve to be fully and fairly compensated for their critical work, such as Council Member Joseph's Resolution 0583. Missing from the roadmap, however, is the enormous cry from the entire human services sector for a COLA of at least 6.5%. Low and non-competitive wages, insufficient reimbursement of services, unreasonable staffing models and supervision options, and lack of meaningful support for staff who encounter trauma all contribute to an acute labor crisis. We appreciate the many ways this roadmap acknowledges this, but we need to push things further to achieve #JustPay and fund the COLA.

Additionally, we want to thank Council Majority Powers for the focus on City and state coordination to increase supporting housing development and contracting with Resolution 0588. We look forward to working with the Council Member on strategies to ensure City and State coordination and hold each entity accountable to completing their goals.

As members of the Correct Crisis Intervention Today Coalition (CCIT-NYC) advocating for a non-police peer-led mental health crisis response, we want to thank the council for the commitment to hold an oversight hearing on the B-HEARD program to address the significant challenges and concerns with the ways the program is currently being implemented, with well over 80% of responses still being handled by police. The City should allocate $190 million to fund the model proposed by CCIT-NYC– which is peer-led, operates 24/7, utilizes a number other than 911 like 988, has independent emergency medical technicians, fast response times, is community operated and culturally response, none-of which are represented in B-HEARD.

Thank you for this opportunity to testify and we look forward to partnering with the Council to build upon this plan, with the goal of implementing a thoughtful and responsive framework to advance mental health and safety in New York City.

May 2nd, 2023

New York City Council Committee on Mental Health,
Disabilites and Addiction

TIMES SQUARE ALLIANCE

Good morning, Chairperson Lee and members of the City Council Committee on Mental Health, Disabilities and Addiction. My name is Ellen Goldstein, and I am the Senior Vice President of the Times Square Alliance, the business improvement district that exists to make Times Square clean, safe, and desirable for all.

Thank you for scheduling this hearing focused on one of the most important issues facing New York City today. We are all aware of the mental health emergency taking place in our city streets and subways, created by decades of ineffective policies, lack of sufficient resources and coordination, and exacerbated by the COVID-19 pandemic. As it stands, it is clear that our current systems are overburdened and ill-equipped to respond to the current crisis.

The Times Square Alliance is committed to serving our community members struggling with mental health and housing insecurity. During the height of the pandemic, we began working with the Center for Justice Innovation, Midtown Community Court, Breaking Ground, and Fountain House to pilot a first of its kind initiative, Community First. Using outreach case managers, Community First connects the unhoused population of Times Square to critical services. Through Community First, outreach case managers build trusting relationships with vulnerable folks out in the street, and only then connect them with services. Building a relationship first, understanding the totality of a person's needs, starting by offering basic supplies such as warm blankets and food, all help open the door to accepting more intensive services when ready.

Our team meets community members where they are – in our community. Since the start of the program in July 2021, we have engaged 996 individuals over the course of 2,992 interactions. We provided mental health services to 35 individuals and connected 43 individuals with housing. Overall, we reduced the number of overnight sleepers in our district by 30%. Because we focus on building trust with each client and meeting their individual needs, this is an intensive process. On average, it takes 20 interactions to get a community member to accept housing, and 16 interactions to accept mental health services.

Beyond our street outreach, we collaborated with Fountain House to launch the Recharge Station, an outdoor kiosk located on Broadway that serves people in need who are experiencing homelessness, mental illness, and loneliness. Everyone is welcome to visit the kiosk to charge their phone, enjoy a free cup of coffee, or chat with a peer. The kiosk provides a central point where community members can connect with social workers and case managers.

Following the strong success of the Recharge Station, the Times Square Alliance hopes to open an indoor community center. This center would serve as a clean and welcoming recreation space for

hanging out, a place to get a shower, a haircut or do some laundry, and also a trusted place to connect with services if desired.

The Times Square Alliance applauds the Council's Mental Health Roadmap and stands in full support of the legislation proposed today. Int. 1022 sponsored by Council Member Riley, establishing community centers for individuals with severe mental illness in high-need areas of New York City, defines "community center" as a community-based location supporting the recovery of these individuals. It is important to uphold the "community" aspect of this definition – these individuals see our neighborhoods as their own. Our proposed Community First storefront would be exactly this – a center built by the community for the community. We urge the Council to consider more flexibility in the rules guiding the funding, placement, and programming of these centers so they can meet the unique needs of the communities that they serve.

TIMES SQUARE ALLIANCE

In addition to the Council's Mental Health Roadmap, we would also like to express our support for the Supportive Interventions Act, legislation the Adams Administration is hoping will be considered by the state focused on critical changes to the NYS Mental Hygiene Law (MHL). The outdated MHL of 1972 erects barriers mental health providers often face when helping individuals avert psychiatric crisis. The Supportive Interventions Act creates new standards for mental health interventions and recognizes the inability to meet basic needs as a form of danger-to-self, mandating treatment. The Act also broadens the mental health professionals qualified to assess community members in crisis, which will help to alleviate the severe shortage in practitioners.

The Times Square Alliance thanks the Committee for the opportunity to provide testimony and applauds its commitment to ensuring that New Yorkers in crisis get the level of care they deserve. We look forward to working with the members of the Committee to advance meaningful policy changes and truly confront one of the most important issues facing our city.
Thank you for your time and consideration.

Ellen Goldstein
Senior Vice President, Policy, Planning & Research
Times Square Alliance

New York City Council Committee On Mental Health, Disabilities and Addiction Meeting May 4, 2023

To: The Honorable City Councilmember Linda Lee

From: Daniel Donoghue, Chief Operating Officer, Transitional Services for New York, Inc.

Dear Councilmember Lee,

We appreciate the opportunity to submit testimony to the Committee on Mental Health, Disabilities and Addiction on behalf of Transitional Services for New York, Inc. We support the Committee's efforts under your leadership to make significant advancements in New York City's mental health system of care. These measures will bolster services in the City that meet the needs of individuals pursuing mental health recovery in its many forms and address the burgeoning demand for mental health care. We strongly support the bills introduced today, and particularly stand behind the bill (INT. 1021-2023) introduced to create 10 crisis respite centers in New York City.

TSINY is a nonprofit organization in New York City, founded in 1974 to provide a range of services to individuals with serious mental illness. TSINY offers a wide range of support including mental health treatment, case management, employment support, educational support, social determinant support, and peer support. We presently operate Miele's Crisis Respite, a 10-bed respite program located in Queens. The Miele's Crisis Respite is one of four respite programs located in New York City developed under the New York City Department of Health and Mental Hygiene's Parachute NYC program. The Parachute NYC program was developed through a three-year Healthcare Innovation grant from the Centers for Medicare & Medicaid Services. The four respite programs were intended to be a demonstration project to gauge the effectiveness of a systems transformation in NYC, aimed at providing an open-door crisis support alternative to utilizing hospital-based care for mental health crises. The crisis respites provide an innovative approach to crisis care, offering evidenced based interventions to alleviate mental health crises, link individuals to community-based supports, and build skills to mitigate and manage future mental health crises.

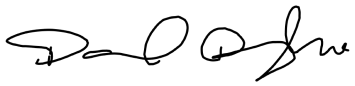
The Parachute NYC respite programs have maintained the goal of providing innovative care, improving health outcomes, and reducing the cost of care. Overall, using a respite program results in a health care savings of $6,000 for each respite guest in the in the 6 months following a respite stay[1]. Most importantly, reductions were most pronounced amongst respite guests who were considered high utilizers of the Medicaid system prior to their respite stay. The reductions in healthcare spending occurred alongside improved health outcomes for respite guests. Respite utilization is associated with a

[1] Bouchery, E. E., Barna, M., Babalola, E., Friend, D., Brown, J. D., Blyler, C., & Ireys, H. T. (2018). The effectiveness of a peer-staffed crisis respite program as an alternative to hospitalization. *Psychiatric Services*, *69*(10), 1069-1074.

significant decrease in ER utilization, a significant decrease in hospitalization, a significant improvement in mental health symptoms, improvements in social functioning, and increased feelings of self-efficacy for up to a year following a stay.

The Parachute NYC Respite programs were intended to act as a proof of concept that crisis alternatives are a viable way to reduce the reliance on hospital-based mental health care in emergency and inpatient departments. The crisis respite programs demonstrate that crisis care can be provided in a voluntary open-door environment and can deliver better outcomes than could be expected in hospital-based care. The proposal to expand the number of respite programs in New York City is a promising step forward and builds upon New York City's success with the respite demonstration project. The current capacity of the four respite programs simply cannot meet the needs of New York City and expanding the availability of crisis respite programs will be a significant development in meeting this need.

Respectfully,



Daniel Donoghue
Chief Operating Officer

UNITED NEIGHBORHOOD HOUSES
45 Broadway, 22nd Floor, New York, NY 10006
212-967-0322 | www.unhny.org

Testimony of United Neighborhood Houses
Before the New York City Council

Mental Health Roadmap Legislative Package Hearing

Committee on Mental Health, Disabilities, & Addiction
Council Member Linda Lee, Chair

Submitted by Nora Moran, Director of Policy & Advocacy
May 4, 2023

Thank you for convening today's hearing. United Neighborhood Houses (UNH) is a policy and social change organization representing 46 neighborhood settlement houses, including 40 in New York City, that reach over 765,000 New Yorkers from all walks of life at 770 locations. A progressive leader for more than 100 years, UNH is stewarding a new era for New York's settlement house movement. We mobilize our members and their communities to advocate for good public policies and promote strong organizations and practices that keep neighborhoods resilient and thriving for all New Yorkers. UNH leads advocacy and partners with our members on a broad range of issues including civic and community engagement, neighborhood affordability, healthy aging, early childhood education, adult literacy, and youth development. We also provide customized professional development and peer learning to build the skills and leadership capabilities of settlement house staff at all levels.

UNH members provide a wide variety of mental health and substance abuse services to their communities, such as Article 31 mental health clinics, Article 32 substance abuse treatment programs, PROS programs, Geriatric Mental Health, and many others. Through these services, settlement houses have established themselves as critical partners in the City's long-term recovery from the COVID-19 pandemic. The pandemic has resulted in enormous new mental health needs, including across-the-board increases in anxiety, depression, isolation, and grief. It is more critical than ever that the City invest in mental health services.

We applaud the City Council for releasing a Mental Health Roadmap at a time when the need for accessible, quality mental health care is at an all time high.

Additionally, we appreciate that the Council is considering the actions that the City can take to improve access to mental health services, but also emphasizes reforms that must happen at the state and federal levels. Mental health policy is complex, with city, state, and federal mandates all weaving together to create the current system. We cannot think about reforming the system at any one level, but have to take a holistic approach when improving policy.

This testimony will comment on several pieces of legislation that the Council is considering as part of the Mental Health Roadmap. This testimony will also focus on several key recommendations for the FY 2024 budget, including:

- Restore all funding for the Council's Mental Health Initiatives at $25.2 million, and rebrand the Geriatric Mental Health Initiative
- Create a new $3 million Youth Mental Health Council Initiative
- Invest $28.5 million to expand school-based mental health clinics
- Support human services workers with a 6.5% cost of living adjustment and considering prevailing wage legislation

Intro 1019

Intro 1019 (Lee) focuses on increasing public awareness and knowledge about mental health services available to the public by requiring the City to create a database and map of outpatient mental health services in the city. UNH supports Intro 1019, as long as the database is not duplicative of other efforts or tools that currently exist to help individuals find outpatient care. It is crucial that this database be accessible in multiple languages, and if possible, indicate what languages a given provider can provide services in. It will also be important that the City's network of community-based organizations know about the database and share information about it with clients. We do not want to see a database created that simply lives unused on a website; and increasing awareness of the tool among CBOs, especially those who do not provide mental health services, will be important.

Intro 1018

Intro 1018 (Lee) requires 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 Mental Hygiene Law Sections 9.41 and 9.58. UNH supports Intro 1018, as having transparency and data around any mental health intervention will help gauge its effectiveness and ensure that the City is using appropriate tools to improve mental health outcomes. As long as this information is made public in a way that does not violate any privacy laws, it will be crucial to know where involuntary removals are occurring and who they are impacting. Having this information will help the City to gauge whether this is an appropriate intervention that is resulting in greater hospitalization for those experiencing severe mental illness, the policy's purported goal.

Intro 1021 and 1022

Intro 1021 (Powers) and 1022 (Riley) both focus on the creation of new programming to support those struggling with mental health issues. Intro 1021 focuses on creating more crisis respite centers, and Intro 1022 would require the City to start a pilot program to expand access to clubhouse style centers for those with mental illness. It is clear that our City needs greater services to support those with mental health challenges, especially those experiencing severe mental illness. Increasing programming that helps those experiencing emotional crisis and provides support before an episode becomes worse is an important goal. UNH supports intro 1021 and 1022, and encourages the City to designate funding to make these bills feasible.

UNH supports creating mental health programming that is accessible and embedded within neighborhoods, making it easy to access. Settlement houses that offer mental health services understand the value of making that support easy to access in non-stigmatizing spaces. They also know that providing other wrap around services in the same location offers greater holistic supports to someone and can help support their overall recovery and well being. If these bills were to pass, we encourage DOHMH to ensure that other wraparound supports are offered at the crisis respite centers and clubhouse programs. Having staff who can help provide mental health treatment but also ensure that someone has stable housing, access to child care, or enough food to eat will be important for helping someone's overall recovery.

Additionally, UNH makes the following recommendations for funding in the FY24 budget to support mental health services.

Restore $25.2 Million in Funding for Council Mental Health Initiatives

In FY 2024, UNH recommends the City Council restore funding to all nine of the previously-funded DOHMH Mental Health Council Initiatives, including: Autism Awareness; Children Under Five; Court-Involved Youth Mental Health; Developmental, Psychological, & Behavioral Health; Geriatric Mental Health (GMHI); LGBTQ Youth; Mental Health Services for Vulnerable Populations; Opioid Prevention and Treatment, and last year's new addition of Trauma Recovery Centers – totalling $25.2 million in funding. Twenty UNH members provide services through City Council Mental Health initiatives.

We greatly appreciate the Council's long-standing support for these programs that bring mental health services to vulnerable populations in their own communities. Year after year, these initiatives provide crucial funding to nonprofit providers to offer mental health services in non-clinical community settings, including community centers, senior centers, and early childhood programs. Despite the fact that the funding must be restored each year by the Council instead of being on more stable multi-year contracts, the funding is flexible and allows providers to best meet their hyper-local needs through creative solutions to distinct mental health challenges. Further, while many mental health programs were baselined by the City as part of the 2015 ThriveNYC initiative, these Council initiatives continue to be important because several of the Thrive programs changed scopes of services and were structured in a way that prevented existing providers from applying. For example, many settlement houses were excluded from applying to serve as host sites for the DFTA Geriatric Mental Health Program (DGMH) due to rigid selection methodology.

After a devastating FY 2021 where many of these initiatives were significantly cut due to the poor economic outlook related to COVID-19, in FY 2022 these initiatives were restored and many were increased above previous levels, allowing new sites to access services and supporting much-needed increases for existing programs. FY23 generally maintained this funding, with some adjustments, while funding a new initiative of Trauma Recovery Centers. The CBOs that were selected to run these trauma centers are still working to get up and running as of March 2023. **It is crucial that the Council at a minimum restore all of this funding in the FY 2024 budget ($25.2 million total).**

Specific funding levels in FY23 that must be maintained in FY24 include:

Geriatric Mental Health Initiative	$3,405,540 (18 settlement houses receive this funding)
Children Under Five	$1,787,000 (2 settlement houses receive this funding)
Autism Awareness	$3,316,846 (3 settlement houses receive this funding)
Developmental, Psychological, & Behavioral Health	$2,255,493 (2 settlement houses receive this funding)
Court-Involved Youth Mental Health	$3,425,000 (1 settlement house receives this funding)
Mental Health Services for Vulnerable Populations	$3,933,000 (1 settlement house receives this funding)
Opioid Prevention and Treatment	$3,500,000
LGBTQ Youth Initiative	$1,200,000
Trauma Recovery Centers	$2,400,000

Geriatric Mental Health Initiative

UNH is a long-time supporter of the Geriatric Mental Health Initiative (GMHI). GMHI funds mental health services in community spaces where older adults gather, such as senior centers, NORCs, and food pantries. GMHI increases the capacity of community-based organizations serving older adults to identify mental health needs, provide immediate mental health interventions, and refer clients for further psychiatric treatment when necessary. By placing mental health services in nonclinical settings, GMHI providers are able to improve access to mental health services in the community, and providers can adapt their programs to meet the needs of the community they serve without stigma. GMHI currently supports 35 organizations, 18 which are UNH members.

Even before the COVID-19 pandemic hit, the aging services network expressed an overwhelming demand to expand mental health services for older adults, especially at senior centers and NORCs and in multiple languages. Given patterns of increased demand since the start of the pandemic, we are thrilled that the Council funded a significant expansion to this program in FY22, allowing the program to reach 13 new sites and supporting long-needed increases for existing providers.

While contract registration and payment have been delayed – a systemic problem across human services contracts across the City that must be addressed – providers report very positive results from this new funding. One newer GMHI recipient uses the funding across their aging services programs to screen, identify, and refer seniors to mental health services. A staff member notes: "I was pleased with the amount of data we were able to obtain from the screenings. It has helped us enhance current programming. For example: our Senior Companion Program has added onsite activities for their senior volunteers to have more interaction and engagement with their peers." Another newer recipient notes that they used the funds to bring on a bilingual worker, and trained case workers across their senior centers to conduct mental health and substance abuse screenings. In their first year in FY22 they screened over 400 older adults. A long-time GMHI recipient used their funding increase to strengthen individual and

group mental health programming, and to expand training opportunities for staff and clients. They note that "COVID-19 and the subsequent variants posed challenges in shifting to remote services, however, GMHI was successful in engaging and supporting clients with no service gaps in counseling, groups, or other services." Given the vast success of this program, we urge the Council to restore full funding to GMHI of $3,405,540 in FY 2024.

It is important to note that this program is different from the DFTA/NYC Aging Geriatric Mental Health Program, which contracts with 4-6 large borough based providers to send mental health clinicians into 88 Older Adult Centers. Due to frequent confusion between these two similar but distinct programs, we urge the Council to rename GMHI to Older Adults Mental Health Initiative or a similar variation this year. Notably, participation in the DFTA program is bound by space requirements and other State licensing rules, reinforcing the need for this community-based and flexible initiative.

Children Under Five

The Children Under Five (CU5) initiative provides early childhood mental health services to infants, toddlers and pre-school aged children and their families in community-based settings. The program allows organizations to work with children to develop psychosocial and educational skills, as well as to cope with trauma resulting from witnessing or experiencing domestic violence, sexual abuse, or physical or mental abuse. Using a trauma-informed lens, providers are able to provide screening and clinical evaluation, individual, small group, and child-parent psychotherapy, and consultation to pediatricians, teachers, and child welfare workers. For years, CU5 providers have been testing new interventions and models of providing care, greatly contributing to the City's understanding of the most appropriate ways to treat this population. Their expertise is essential in both working on complex cases and in putting forth new treatment options. CU5 currently supports 13 organizations, including two UNH members. This program could serve a key role in meeting the mental health needs of recent asylum seekers.

CU5 underwent a large expansion in FY22, increasing the number of providers from 4 to 13 citywide and offering increases to existing providers. UNH members had been requesting such increases for many years. In FY 2024, the program should be restored at $1,787,000.

Autism Awareness

The Autism Awareness Initiative supports wraparound services for children with Autism Spectrum Disorder (ASD) at 39 organizations across New York City, including 3 UNH member organizations. Services offered include after-school programs, summer camps, social skill development, and weekend programming, as well as supportive services for families and caregivers of children with ASD. These programs often fill crucial gaps in services, such as extended support beyond State services under the Office of People with Developmental Disabilities Services (OPWDD), weekend and summer programming, and supports for young adults who have aged out of the OPWDD system but still need support around vocational and life-skills coaching. Autism Awareness providers also offer family support and coaching, so that parents of children with ASD have resources to care for their children, and supports for themselves to prevent against caregiver burnout. In FY 2024, we ask the Council to restore Autism Awareness at $3,316,846.

Developmental, Psychological, & Behavioral Health
Developmental, Psychological, & Behavioral Health supports a range of programs and services that address the needs of individuals with substance use disorder, developmental disabilities, and/or serious mental illnesses, as well as the needs of their families and caregivers. The funding may support medically supervised outpatient programs, transition management programs, Article 16 clinics, psychological clubs, recreation programs, or other behavioral health services. This initiative reaches 18 organizations including two UNH members. In FY 2024, the Council should restore the Developmental, Psychological, & Behavioral Health initiative to $2,255,493.

Court-Involved Youth Mental Health
The Court-Involved Youth initiative supports programs that help identify teenagers with criminal justice involvement who require mental health services. The initiative provides assessments, family services, counseling, and respite services, and connects participating youth and families with additional services. This initiative supports 23 organizations including one UNH member. In FY 2024, the Council should restore the Court-Involved Youth Mental Health initiative at $3,425,000.

Mental Health Services for Vulnerable Populations
The Mental Health for Vulnerable Populations initiative supports community-based behavioral health programs that provide a range of programs, services, trainings, and referrals to support vulnerable and marginalized populations, including people who may be HIV-positive, suicidal, schizophrenic, or have developmental disabilities, as well as broader population groups such as children and youth, immigrants, homeless individuals, and at-risk seniors. This program received an increase in FY23, and currently supports 47 organizations including one UNH member, and should be restored at $3,933,000 in FY24.

<u>Create a $3 Million Youth Mental Health Council Initiative</u>

During the first few months of the COVID-19 pandemic, 1 in 600 Black children and 1 in 700 Latinx children lost their parent or caregiver to the pandemic in New York State, more than double the rate of white children. More than half of those parent deaths were in the Bronx, Brooklyn, and Queens. Losing a caregiver is associated with a range of negative health effects, including lower self-esteem, a higher risk of suicide, and symptoms of mental illness. According to pediatricians, addressing the impact of family death on young people will "require intentional investment to address individual, community, and structural inequalities." Beyond grief, the learning loss and isolation has had an extreme impact on young people. In late 2021, the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP) and the Children's Hospital Association (CHA) declared a National State of Emergency in Children's Mental Health; and the Surgeon General followed suit by declaring a Youth Mental Health Crisis.

Given these growing mental health needs among young people, we propose using approximately $3 million in new Council Initiative funds to create a new Youth Mental Health initiative. This new initiative would provide flexible mental health services for youth programs run by CBOs – such as Beacons, Cornerstones, COMPASS/SONYC, and others–with a focus on out-of-school time. Programs would be able to hire mental health professionals who are trained to engage young people, lead structured group activities, or test other innovative, tailored solutions to youth mental health needs – much in the same way the Geriatric Mental Health

Initiative functions for older adults. These funds could also offer supports for youth workers when dealing with mental health crises, or creating proactive programming for mental health wellness. Notably, there was an under-allocation for the new Trauma Recovery Centers initiative in FY23 of about $450,000, and we urge the Council to invest additional funds to build a substantive initiative of about $3 million.

Invest $28.5 million in School-Based Mental Health Clinics

The City currently has 280 school-based mental health clinics, which feature community-based providers who operate satellite sites of their licensed Article 28 or 31 clinics in schools. Providers can offer group and individual therapy, clinical treatment, diagnosis, crisis mental health services, support for teachers, family support, and more. These clinics work to improve overall school wellness. They integrate with broader community-based services to support whole families, and seek to reduce punitive measures for children experiencing mental health challenges.

The City should make a robust, $28.5 million investment in expanding school-based mental health clinics in the FY 2023 budget. This funding would support the creation of 100 new sites over the next two years (due to the time it takes for city procurement, state licensure, and securing space and staff) costing $150,000 per program. It would also provide increases of $75,000 per program to the existing 280 providers. Notably, staff retention at existing school-based clinics is a challenge due in large part to a lack of pay parity between community-based providers and DOE-employed professionals, including school social workers.

While clinics receive funding by billing health insurance, this is insufficient because insurance does not cover school wellness activities like mental health education and training; Medicaid does not cover services to children without a diagnosis; and commercial insurance often does not cover the service at all, or pays a rate that is so low that it covers only half of the cost of service. Further, because school-based clinics can bill insurance, which the DOE largely cannot, an investment in clinics will result in an infusion of state & federal dollars into schools, and ultimately cost the City less than hiring a DOE school social worker.

Mayor Adams expressed support for building more school-based mental health clinics in his March 2023 Care, Community, Action mental health plan, though he does not specify whether these clinics would be run by CBOs or directly by schools or DOHMH. We support the Mayor's intention and urge any investments to be steered toward community based organizations who have a strong record of running these types of programs.

Invest in the Human Services Workforce

While it is crucial to examine mental health needs in our City and the programs that address these needs, we must ensure that the workers providing these services are supported. Low wages for community based mental health services have contributed to a staffing crisis, and without increased budgets in government contracts to cover wage increases, nonprofits will be unable to recruit and train the next generation of mental health workers, setting future New Yorkers up for significant barriers to accessing services.

More broadly, human service workers as a sector are grossly underpaid. A recent analysis by UNH found that human service workers face similar economic insecurity as the participants in

their programs; in our report, *The Need to Strengthen the Economic Security of the Settlement House Workforce*, we note that government funding decisions and chronic underinvestment in human services have led to poverty-level wages for essential frontline workers at settlement houses.

Low wages, exacerbated by burnout from the COVID-19 pandemic, have led to chronically low staffing levels at human services organizations. Our settlement house members report more, longer vacancies, higher turnover, and significant challenges recruiting in a competitive labor market. Insufficient staffing has made it increasingly difficult for nonprofits to serve New Yorkers, leading to under-enrollment and program closures – such as the recent announcement of the closure of Sheltering Arms – which then leads to budget reductions and a vicious cycle that harms New Yorkers seeking services.

For years, the human services sector has warned of a staffing crisis citing low wage levels. Over the last two years, the City ignored a COLA request and instead issued a one-time bonus for our workforce that was equivalent to less than 1%, and a "contract enhancement" that led to contract-by-contract increases of between 1.5 and 2.5%. This investment is wholly insufficient to have a meaningful impact on the nonprofit workforce. Even with an annual 5% COLA, for most frontline workers starting at or around minimum wage, five years of raises would still mean an hourly wage of under $20. Coupled with inflation and the City's tendency to extend contracts without any cost escalators or budget modifications, this salary problem will only be solved by a significant investment in the workforce.

Create a Prevailing Wage Schedule for Human Services Workers:
For these reasons, UNH supports Introduction 510 (Stevens), which would establish prevailing wage schedules for human service workers, require agencies to include sufficient funding to cover those wages in contracts, and track implementation of those wages by human service contractors; and we know that this legislation would need to pass through the budget process to be effective. While prevailing wage schedules are an imperfect tool to address the current conditions faced by human service workers, it is a significant improvement from the status quo. This process to design a true prevailing wage system is arduous and will require careful analysis, but we cannot afford to continue ignoring the need. For years, the government at every level has asked nonprofit partners to do "more with less." This dynamic has pushed our sector to a real breaking point, and our workforce has suffered the consequences.

Include a 6.5% COLA for Human Services Workers:
Given the gravity of the human services staffing crisis, we are also supportive of a 6.5% Cost of Living Adjustment (COLA) for this workforce in FY 2024, in alignment with the JustPay campaign. We also ask the Council to ensure it is included in the budget as a "cost of living adjustment" and not some other named initiative so providers can rely on these funds being stable and recurring.

Thank you. To follow up, please contact me at nmoran@unhny.org.

Vibrant Emotional Health

Public Policy

New York City Council

Committee on Mental Health, Disabilities and Addiction

HEARING RE: MENTAL HEALTH ROADMAP LEGISLATIVE PACKAGE

Thursday, May 4, 2023

Testimony delivered by:

Lisa Furst, LMSW, MPH
Chief Program Officer

Hope Happens Here.

Thank you to Councilmember Linda Lee and the Council Committees on Mental Health, Disabilities and Addiction for the opportunity to submit testimony on the Mental Health Roadmap Legislative Package.

Vibrant Emotional Health (Vibrant) has provided.direct services, public education, and advocacy services to New York City for over 50 years. Throughout its history, Vibrant has been engaged in promoting the mental health of children, youth, families and adults, particularly for those living in marginalized communities. Vibrant currently operates a variety of programs providing direct support to youth and families, including three Family and Youth Peer Support services in the Bronx, Queens and Staten Island, three Adolescent Skills Centers in the Bronx, Queens and Manhattan, as well as preventive programs and Children and Family Treatment and Support Services in the Bronx and Manhattan. These programs serve children and youth living with mental, emotional or behavioral health challenges and works to support them, and their families, to promote emotional health and help them attain their goals for overall wellbeing. In addition, Vibrant operates NYC Well, the City's mental health and emotional support hotline, which is available 24/7 to support youth with mental health needs and their parents/caregivers, and administers the national 988 Suicide and Crisis Lifeline.

Vibrant has not only witnessed firsthand the challenges associated with the COVID-19 pandemic, but also recognizes the reality that the mental health crisis did not begin during the pandemic. The crisis has been longstanding, and the pandemic served to dramatically exacerbate already worsened mental health outcomes. We've seen the direct impact inadequate public investments and ineffective policy has left many New Yorkers without comprehensive, holistic, and culturally responsive mental and behavioral healthcare. Vibrant is heartened that the Mental Health Roadmap Legislative Package could begin to provide investments in **prevention and supportive services**; address issues with **workforce shortage;** provide solutions for the **intersection of mental health and the criminal justice system**; and offer better coordination with regard to **public awareness and interagency community**.

There is a long-standing issue regarding prevention and supportive services, including but not limited to: 1) **overall lack of culturally and linguistically competent services** widely available in each of the boroughs; 2) **long wait lists for those services that are available**, increasing the likelihood of mental health crises among youth and subsequent visits to emergency departments; 3) **encountering clinicians who are not trained in the most current, evidence-based treatment methods for addressing acute mental health symptoms**; 4) **lack of capacity to provide evidence based treatments for trauma** as well as other trauma-informed practices; 5) **high clinician turnover in agency-based practice**, resulting in treatment delays and interruptions; 6) **encountering unsafe conditions while traveling to and from treatment** locations; and 7) **challenges utilizing telehealth services for many individuals**, particularly if they are not equipped with the necessary technology or homes are not adequately equipped with broadband internet access.

Vibrant is particularly pleased that the Council will continue advocating for adequate funding in the city's FY24 budget to expand school-based mental health services, including the additional investment of $28 million to strengthen existing school-based mental health clinics and establish additional sites across all five boroughs. It is also important that funding be made available to ensure New York City education settings have the resources they need to implement mental health education to students in grades K-12, as mandated by New York State law.

We are seeing an ever-increasing demand for mental health services as the workforce shortage for mental health providers increases. The workforce shortage is a direct result of decades of disinvestment in the mental healthcare system, which caused non-competitive salaries, insurance coverage that does not adequately ensure that people have access to services, educational and training programs that fail to recruit and retain sufficient talent, and bureaucracies that prevent ease of practice for clinicians.

In order to address these workforce challenges, **the City should provide additional discretionary funds to recruit for vacant positions, increase wages for existing roles, and expand programs to better meet community demand for services.** In addition, **New York City should establish, fund and ensure an automatic annual cost of living adjustment (COLA)** for all city mental health contracts in order to enable organizations to retain staff and reduce turnover.

Additionally, **the City should incentivize growth in the mental health workforce by instituting loan forgiveness programs and direct tuition assistance for mental health professionals committed to agency-based practice in public and non-profit settings**. As many clinical positions require certification or licensure, **it is also important that the City provides funding to support test preparation and fees** associated with obtaining these credentials. For positions that do not require a master's degree or licensure, such as those in case or care management, family and/or youth peer support and other roles, **contracts must ensure salary scales are required in order to keep wages in pace with the cost of living and are competitive enough to attract workers to the sector**.

One important barrier to care is the lack of services available in those settings where individuals are confined, including confinement settings and jails and/or prisons. Involvement in the criminal justice system also plays a direct role in the worsening of health outcomes, especially those with serious mental illnesses and mental health challenges. An estimated 12% of New York State's prison population has a serious mental illness – about five times as many people as there are beds in the correctional hospital system. Vibrant is pleased that the Mental Health Roadmap Legislative Package prioritizes a holistic community response that does not employ or rely upon policing facilitates. Vibrant also supports the City Council's plan to advocate that people living with serious mental illness have access to safe, affordable supportive housing and accompanying services, as without adequate housing, people living with mental illness are at increased risk of being involved with the criminal justice system.

While New York is resource-rich compared to other states, mental healthcare is only accessible with a coordinated strategy of public awareness and interagency communication. **It is critical that all communities, especially those historically and currently marginalized, receive mental health education to raise their awareness of common mental health challenges and increase their knowledge of available support systems** . As the NYC Well program already maintains a comprehensive database, including outpatient services, which can also be directly accessed by the public on the NYC Well website, **Vibrant does not recommend that the City Council legislate to provide a separate dataset and resource**, but should ensure continued funding to maintain the robust resource database that currently exists, while also supporting public awareness campaigns that can drive New Yorkers to this resource.

Moreover, there must be comprehensive, efficient, and culturally-competent mental healthcare infrastructure, which will require the coordination of private, nonprofit, and public actors in the provision of mental healthcare and services, and public awareness. **Federal, state, and local actions must be provided specially to increase the efficiency and effectiveness of 988, the new three-digit number for the Suicide and Crisis Lifeline, as well as to ensure that 988 contacts are routed by geolocation rather than area code.**

Thank you for this opportunity to submit this testimony. We are grateful for the New York City Council having made this opportunity possible, and we are available at the Council's convenience to assist in its efforts to support the mental health and wellbeing of all New Yorkers.

220 East 42nd Street
New York, NY 10017
212.609.5555
vnshealth.org

VNS Health Testimony to the New York City Council Committees on Mental Health Developmental Disabilities and Addictions
Oversight: Mental Health Roadmap Legislative Package
Thursday, May 4, 2023

Chair Lee and Councilmembers Abreu, Ayala, Bottcher, Cabán, Hanif, Mealy, and Williams, thank you for the opportunity to submit testimony regarding the Council's Mental Health Roadmap Legislative Package. My name is Jessica Fear, and I am the Senior Vice President of Behavioral Health at VNS Health. I also serve on DOHMH Commissioner Ashwin Vasan's Stakeholder Committee to support people with Serious Mental Illness (SMI).

VNS Health (formerly the Visiting Nurse Service of New York), a nonprofit that has operated continuously for almost 130 years, is the largest home and community-based healthcare organization in New York. We provide care to more than 43,000 New York State (NYS) residents each day, including offering high-quality Medicaid and Medicare health plans for seniors, people with disabilities, and people living with HIV/AIDS, in addition to operating the largest certified home health agency (CHHA) and hospice in NYS. We have offered a suite of behavioral health programs for over 35 years, serving over 20,000 at-risk and SMI New Yorkers last year alone. VNS Health has deep roots in the history of New York ensuring these populations have access to cost-effective healthcare services in their communities and in the comfort of their own homes.

With critical support from the New York City Department of Health and Mental Hygiene (NYC DOHMH), the NYC Council, and the New York State Office of Mental Health (NYS OMH), VNS Health provides home and community-based behavioral health treatment and case management services to vulnerable adults, children, and adolescents in every borough. We employ over 475 clinical staff, including licensed Behavioral Health Professionals, Psychiatrists, Psychiatric Nurse Practitioners, Care Managers, Outreach Workers, and Peers. Our programs include six Mobile Crisis Teams (MCTs), five Assertive Community Treatment (ACT) teams, five Intensive Mobile Treatment (IMT) teams, 3 Home-Based Crisis Intervention (HBCI) teams, an Article 31 Clinic, and first responder mental health first aid training.

New York City's Mental Health Crisis

We commend the City Council, the Adams Administration, and the Hochul Administration for shining the spotlight on the mental health crisis and for providing the collaboration and resources necessary to address it over the past few months.

So many of us are struggling to cope with what is happening around us – COVID, the fracturing of families and institutions, implicit and overt racism, violence, economic dislocation, our changing climate, and more. The individuals and families we serve are no different from you and me, except they exhibit a higher incidence of trauma, anxiety, and depression. They often need assistance accessing benefits and basic necessities such as housing, food, and medication. Our mental health crisis took root well before COVID. However tragic incidents like what happened on the F Train recently, where a young man by the name of Jordan Neely was choked to death by a passenger while he was experiencing a mental health crisis bring a renewed spotlight on the urgent need for system reform. We all know that the "upstream"

investments are critical to mitigate the “downstream” effects on individuals and our city. Systemic underinvestment in the institutions that keep people from falling through the cracks – behavioral health treatment capacity, family and youth support programs, and community-based programs for seniors and marginalized populations – has increased the number of vulnerable individuals suffering as a result.

Proposed Legislation and Resolutions

VNS Health applauds Chair Lee and the NYC Council for developing the Mental Health Roadmap, a set of bold, thoughtful proposals that will make significant progress in helping us tackle the city’s mental health crisis. From our longstanding experience serving these populations we would like to express support for the following policies/proposals:

- Sufficient funding to expand IMT teams and ACT teams.
- Increased funding for contracted behavioral health organizations that provide culturally competent and linguistically diverse mental health supports and services. This funding will underwrite long-standing budget deficits and allow these organizations to increase wages to improve recruitment and retention of critical staff.
- A CUNY Social Work Fellows Program and subsidized mental health education, degrees, and licensing, particularly for students who commit to working in public interest mental health professions.
- Additional funding in contracts to achieve pay parity between mental health workers in city government and the non-profit sector providing similar services.
- Expanding school-based mental health services, including the additional investment of $28 million to strengthen existing school-based mental health clinics and establish additional sites across all five boroughs.
- Funding the Mental Health Continuum, a cross-agency partnership to provide mental health support to all students.
- Establishing programs that help families navigate relationships with loved ones experiencing a mental health disorder, including peer-led and family support groups, family therapy, and supportive counseling programs.

VNS Health supports all the legislation and resolutions being considered in today’s hearing:

- **Int 1006-2023**, to implement an outreach and education campaign regarding mental health services that can be accessed under NYC Care.
- **Int 1018-2023**, to require DOHMH, in conjunction with NYPD and other agencies, to provide an annual report to the Council about involuntary removals conducted pursuant to 9.41 and 9.58.
- **Int 1019-2023**, to require DOHMH to develop and maintain a searchable electronic database and an interactive map of outpatient mental health service providers with actionable information and allow providers to request inclusion.
- **Int 1021-2023,** to require each borough to have at least two crisis respite centers open to walk-ins and referrals.
- **Int 1022-2023,** to create a pilot program that would establish community centers for individuals with severe mental illness in high-need areas of NYC.
- **Res 0088-2022**, to call on Congress to and the President to fully repeal the Institutions for Mental Diseases Exclusion from the Social Security Act.

- **Res 0583-2023,** to call on NYS to subsidize the education and licensing costs of CUNY students who commit to working in the public sector in the mental health professions.
- **Res 0584-2023,** to pass 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 0587-2023,** to call on NYS OMH to expand enforcement of mental health and substance use disorder insurance parity and apply for federal grants to enforce insurance parity.
- **Res 0588-2023,** to call on NYS to reinitiate the NY/NY supportive housing program.
- **Res 0589-2023, to call 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 0592-2023,** to call on NYS and the 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.

Additional Recommendations for Improved Mental Health Services

I cannot stress enough how imperative it is for community-based mental health programs to be sufficiently funded to prevent unnecessary hospitalizations and provide more cost-effective and stable patient care. Below are our recommendations for enhancements to the system that will support meaningful change for the people we serve:

- **Expand Mobile Crisis Team (MCT) capacity**: MCTs deploy clinically trained professionals within a 2-hour timeframe to de-escalate, engage, conduct a face-to-face assessment of psychiatric risk and risk of harm, and connect individuals to the right level of care at the right time. To that end, only 5% of our Mobile Crisis clients are transported to the emergency room, with 3% of adults and 1% of youth under 21 transported involuntarily. The remainder is maintained successfully in the community. Between 2018 and 2022, we have seen MCT referrals more than double for adult, child, and family services. We recommend funding to expand MCT capacity and specifically to increase the number of Children's MCTs (currently only 1 per borough) to ensure that all MCTs have the resources to respond quickly to a crisis.
- **Support Home-Based Crisis Intervention (HBCI):** Preventing a crisis from escalating is critical to reducing the frequency of involuntary hospitalizations. VNS Health's Home-Based Crisis Intervention (HBCI) teams provide short-term intensive in-home intervention to families in crisis due to the imminent risk of their child being admitted to an inpatient psychiatric unit. As a result of the pandemic and the escalated youth mental health crisis, this program has been over capacity since 2021. Additionally, program funding runs lower than salary and expenses by about 40%, leading to challenges with recruitment and retention of skilled staff. While recent program enhancement funds have been added to the budget, they are still not sufficient to cover basic operating expenses for this incredibly effective program. We strongly recommend additional investments by funding entirely new HBCI teams with enhanced budgets for improved salaries and increased capacity.

- **Crisis intervention and 9.58 training for non-behavioral health service providers**: In recent months, VNS Health has experienced increasing situations where clients in crisis encounter non-behavioral health service providers, and the interaction escalates to an untenable scale before we can intervene. These situations nearly always result in a poor outcome for the person experiencing the mental health crisis. All personnel in positions where they could encounter individuals experiencing a mental health crisis, including non-first responder personnel in the NYPD, MTA, DOE, and NYCHA, should receive behavioral health crisis intervention training. Further, NYPD, FDNY, and EMT first responders need to be properly trained to assist with transporting people to emergency departments when deemed necessary by the MCT.
- **Public safety for behavioral health field staff:** We are getting more consistent reports from our field-based staff finding themselves in unsafe situations, and we are fielding more frequent safety threats related to harassment, discrimination (particularly our Asian staff), assault, and property crimes. The threats do not come from our clients but from the areas where we engage with them. We are providing – at our own cost – car service expenses and walking escorts to accompany our staff when necessary. Public safety directly impacts staff recruitment and retention and, by extension, access to care in the community for the people who need it most.

Thank you for your continued leadership in addressing New York City's mental health crisis.

Sincerely,

Jessica Fear, LMFT
Senior Vice President, Behavioral Health
VNS Health

Jessica Fear

Testimony to the City Council Committee on Mental Health, Addiction, and Disabilities

URBAN JUSTICE CENTER | Freedom Agenda

May 4, 2023

Good afternoon Council Member Lee, and thank you for opportunity to testify today.

My name is Corinne Conrad, and I am a member of Freedom Agenda, and the grandmother of a young man with a mental illness who has been on Rikers Island for more than two years. I am grateful to see that our City Council has created a real plan to address the mental health crisis in our City, and I want to encourage you to take every action necessary to turn this plan into reality NOW.

People that go into Rikers Island with Mental Illness, which most likely contributed to why they're in there, without proper treatment or preventative resources, are most certainly going to come out worse than prior to entering. The Mayor might say we are incarcerating people in the name of "safety" but anyone who has experienced Rikers knows that it has the opposite effect.

If there were preventative resources in communities to assist those struggling with Mental illnesses, it would, without a doubt, decrease the numbers of people in Rikers, and in jail and prisons across the state. There is no logical argument to say otherwise. Mental health programs are not only beneficial to those directly in need but to society as a whole. We speak of the importance community involvement has on bettering individuals as well as the environment, yet are failing greatly on being proactive in the mental health arena. Passing the blame after incidents occur and speaking of "cracks within the system". The need for and importance of community Mental Health programs to be implemented ASAP is due to the fact that Mental Illness, and all that comes with it, has become a critical crisis which requires immediate solutions prior to becoming devastating situations. We maintain our vehicles with more reasonable care than we do humans, why? In order to prevent major problems in the future.

Unfortunately our family did not have the financial means to get the help needed for our loved one who is struggling with mental illness. The limited resources available weren't proactive nor consistent in any way. We were pushed aside and ignored more than dealt with. It's beyond frustrating because our loved one is now a statistic in Rikers Island. There is no treatment for him there as well. We now watch his mental health deteriorate at a rapid pace. We are on a never stopping hamster wheel. Always giving as much support, love, guidance, encouragement, our own definition of therapy and prayers in order to keep him thinking clearly and not place himself in any dangerous situations. The toll it has taken on all of us is beyond measure. We're exhausted, fearful and have high anxiety. We pray that programs in the communities, for mental health are implemented sooner than later because they will most certainly make a difference and contribute to the positive change this City desperately needs.

In conclusion, I am grateful for the opportunity to express why I am in favor of implementing quality mental health programs in our communities, and preventing people from going through what my grandson is experiencing. Again, this will not only be beneficial to those individuals struggling with Mental Health Illness but to Society as a whole. Throughout this country we have teams that formulate emergency response plans for crisis situations. This is without a doubt, a critical situation. Implementing programs is the only logical response. If we want better, we have to do better. We cannot expect change without changing how we're going to make that happen. Thank you in advance for making it happen.

Hi my name is Damyele Baez, I am a member of Fountain House Bronx and I have serious mental illness.

I am grateful to the Council for all your work on improving NYC's mental health care system and excited by much of what we are seeing proposed in the roadmap released a week ago. I wholeheartedly agree that to address the needs of fellow New Yorkers we must think holistically and invest in prevention, community-based care, bolstering the mental health workforce, increasing public awareness of available services, and more.

I am particularly excited to see Council Member Riley's legislation being introduced (Int. No. 1022) that points to the City's commitment to expand clubhouses for people living with serious mental illness. Specifically, the legislation seeks to advance a pilot program to ensure that these community centers are in at least five of the highest-need areas.

Fountain House Bronx currently serves many members in a very high-need neighborhood in the Bronx. The Bronx has the highest prevalence of serious psychological distress in NYC, especially concentrated in the South Bronx. Bronx residents face higher rates of unemployment, challenges with poverty and numerous health disparities, including a critical lack of mental health services.

The clubhouse is important to me because they understand me and we help each other in team. Also, we do event to have fun together. We are different people but one thing we have is we love be together ever. We have our different mental illnesses. I love to come together and I am so happy that I have a place that we are same no matter. When I am not at the clubhouse I feel different; I love to be here. The best thing that I Love is celebrating each other birthday. I love to be at the kitchen cooking is what I love to do. I love when a staff know a member at the hospital come visit them and send birthday cards or get well cards.

10 years ago, Fountain House expanded to have a clubhouse in the Bronx that has greatly impacted the lives of many Bronxites with SMI. But we have run out of space, so in order to continue reaching New Yorkers living with SMI, we need a larger clubhouse.

We have plans to expand that include developing a new 17,000 square foot clubhouse and a residential building with 30 studio apartments. The clubhouse will serve 4x the number of people currently served by the Bronx clubhouse and will provide lasting connections and membership for people for lifetimes and generations. We are eager to close service gaps in this mental health desert and would like to work with the Council to make this expansion a reality.

Thank you very much for reading this and for your consideration.

Hi my name is Eric Justice and I am a member of FH Bronx, person living with Serious Mental Illness.

I am grateful to the Council for all your work on improving NYC's mental health care system and excited by much of what we are seeing proposed in the roadmap released a week ago. I wholeheartedly agree that to address the needs of fellow New Yorkers we must think holistically and invest in prevention, community-based care, bolstering the mental health workforce, increasing public awareness of available services, and more.

I am particularly excited to see Council Member Riley's legislation being introduced (Int. No. 1022) that points to the City's commitment to expand clubhouses for people living with serious mental illness. Specifically, the legislation seeks to advance a pilot program to ensure that these community centers are in at least five of the highest-need areas.

Fountain House Bronx currently serves many members in a very high-need neighborhood in the Bronx. The Bronx has the highest prevalence of serious psychological distress in NYC, especially concentrated in the South Bronx. Bronx residents face higher rates of unemployment, challenges with poverty and numerous health disparities, including a critical lack of mental health services.

Fountain House Bronx is a place where I find peace, belong and help as well as peers. It gives me a chance to grow or improve on basic skills, like cooking, learning, HRA, and how to advocate for oneself. It also helps me budget and learn to cook or prep meals that are good and filing. We also try healthy alternative like smoothies, parfait, trail mix, or other snacks as well as garden, also salad and provides work skills and a place to come when you want to go out or stay active, also help relapse prevention. I am also grateful for the support system of members and staff whether in hospital or need to go somewhere, doctor or other. I have benefited by coming in housing, health, mental, physical, and emotional care. Also we learn CPR, voting and who elected and who officials are and how to go & get assistance in all ways to improve as well stay informed.

10 years ago, Fountain House expanded to have a clubhouse in the Bronx that has greatly impacted the lives of many Bronxites with SMI. But we have run out of space, so in order to continue reaching New Yorkers living with SMI, we need a larger clubhouse.

We have plans to expand that include developing a new 17,000 square foot clubhouse and a residential building with 30 studio apartments. The clubhouse will serve 4x the number of people currently served by the Bronx clubhouse and will provide lasting connections and membership for people for lifetimes and generations. We are eager to close service gaps in this mental health desert and would like to work with the Council to make this expansion a reality.

Thank you very much for reading this and for your consideration.

Hi my name is Jacob Frias, I am a member of Fountain House Bronx and I have serious mental illness.

I am grateful to the Council for all your work on improving NYC's mental health care system and excited by much of what we are seeing proposed in the roadmap released a week ago. I wholeheartedly agree that to address the needs of fellow New Yorkers we must think holistically and invest in prevention, community-based care, bolstering the mental health workforce, increasing public awareness of available services, and more.

I am particularly excited to see Council Member Riley's legislation being introduced (Int. No. 1022) that points to the City's commitment to expand clubhouses for people living with serious mental illness. Specifically, the legislation seeks to advance a pilot program to ensure that these community centers are in at least five of the highest-need areas.

Fountain House Bronx currently serves many members in a very high-need neighborhood in the Bronx. The Bronx has the highest prevalence of serious psychological distress in NYC, especially concentrated in the South Bronx. Bronx residents face higher rates of unemployment, challenges with poverty and numerous health disparities, including a critical lack of mental health services.

Fountain House is important to me because it is my rehabilitation program. It helps me stay away from isolation and keep me busy so that I can focus on doing something

and not stay home and do nothing. Fountain House provides me with services such as independent living skills and supportive housing. Plus, I make friends and eat healthy meals.

10 years ago, Fountain House expanded to have a clubhouse in the Bronx that has greatly impacted the lives of many Bronxites with SMI. But we have run out of space, so in order to continue reaching New Yorkers living with SMI, we need a larger clubhouse.

We have plans to expand that include developing a new 17,000 square foot clubhouse and a residential building with 30 studio apartments. The clubhouse will serve 4x the number of people currently served by the Bronx clubhouse and will provide lasting connections and membership for people for lifetimes and generations. We are eager to close service gaps in this mental health desert and would like to work with the Council to make this expansion a reality.

Thank you very much for reading this and for your consideration.

Hi My name is Joseph Burton, and I am a member of Fountain House Bronx, and a person living with serious mental illness.

I am grateful to the Council for all your work on improving NYC's mental health care system and excited by much of what we are seeing proposed in the roadmap released a week ago. I wholeheartedly agree that to address the needs of fellow New Yorkers we must think holistically and invest in prevention, community-based care, bolstering the mental health workforce, increasing public awareness of available services, and more.

I am particularly excited to see Council Member Riley's legislation being introduced (Int. No. 1022) that points to the City's commitment to expand clubhouses for people living with serious mental illness. Specifically, the legislation seeks to advance a pilot program to ensure that these community centers are in at least five of the highest-need areas.

Fountain House Bronx currently serves many members in a very high-need neighborhood in the Bronx. The Bronx has the highest prevalence of serious psychological distress in NYC, especially concentrated in the South Bronx. Bronx residents face higher rates of unemployment, challenges with poverty and numerous health disparities, including a critical lack of mental health services.

The reason I come to the clubhouse is to better myself in life. Better myself in thinking. Better coming to the fountain house make me face my problem one of the way the clubhouse helps you talking to my friend and staff member store runs

10 years ago, Fountain House expanded to have a clubhouse in the Bronx that has greatly impacted the lives of many Bronxites with SMI. But we have run out of space, so in order to continue reaching New Yorkers living with SMI, we need a larger clubhouse.

We have plans to expand that include developing a new 17,000 square foot clubhouse and a residential building with 30 studio apartments. The clubhouse will serve 4x the number of people currently served by the Bronx clubhouse and will provide lasting connections and membership for people for lifetimes and generations. We are eager to close service gaps in this mental health desert and would like to work with the Council to make this expansion a reality.

Thank you very much for reading this and for your consideration.

My name is Sandra Ellen Brower and I have been living with a mental health condition since 1997. I have been an advocate for over 20 years, including serving on the Board of NYAPRS. I have been a member of Fountain House for a little over a year and my mental health has improved greatly, including a decrease in suicidal ideation.

Finding a community, like Fountain House, that has offered so much support and has allowed for so much choice in my own recovery has significantly impacted my life in a positive way. Now I have a safe and stable place to live. I am taking my own medication. I am a leader in the Fountain House community. At Fountain House I have written articles for the newspaper, I sell healthy snacks on the wellness cart, I take part in all our advocacy initiatives, exercise regularly in our gym, and I present at the weekly Community meeting. I now have an excellent treatment team that is a part of the Fountain House continuum of care. I am alive today because people took the time to care about me, listen to my needs, and allowed me to be an expert in my own recovery.

Too many people living with mental health conditions have little to no say in their treatment and overall lives. Coercion and force are all too common. People with mental health conditions should be regarded as experts in their own recovery and should play an equal role with their treatment team. Community based programs are essential to the recovery of those living with mental health conditions.

We need to listen to those with lived experience and stop judging and stigmatizing those with mental health conditions. We need to reduce the use of AOT and other coercive methods. We need to invest in clubhouses throughout the city so that people can live more fulfilling and productive lives like I am. Time after time, clubhouses have proven that their voluntary and person-centered approach improves lives by

decreasing isolation, providing employment and education support, and reducing hospitalizations and criminal justice recidivism. Clubhouses not only save lives, but they save money.

I am asking that as part of the NYC Mental Health Roadmap, that you invest in expanding clubhouses supports throughout the city. This means not only creating new clubhouses but investing and developing the clubhouses that already exist and have been serving NYC residents for years. For instance, Fountain House Bronx, which is located in the largest mental health desert in the country, can no longer serve more people in their community because they do not have adequate space. We need your help in investing in the Fountian House Bronx Expansion Project. Other clubhouses in NYC do not have enough financial resources to pay their staff livable wages, thus creating staff turnover. Continuity of care and long-term relationships are key to long term recovery for those living with mental health conditions. We need you to invest in our current clubhouse programs and invest in the development of new clubhouses in high needs communities.

Thank you for taking the time to read my testimony.

Hi I am Steve Perez, a member of Fountain House Bronx and I live with serious mental illness.

I am grateful to the Council for all your work on improving NYC's mental health care system and excited by much of what we are seeing proposed in the roadmap released a week ago. I wholeheartedly agree that to address the needs of fellow New Yorkers we must think holistically and invest in prevention, community-based care, bolstering the mental health workforce, increasing public awareness of available services, and more.

I am particularly excited to see Council Member Riley's legislation being introduced (Int. No. 1022) that points to the City's commitment to expand clubhouses for people living with serious mental illness. Specifically, the legislation seeks to advance a pilot program to ensure that these community centers are in at least five of the highest-need areas.

Fountain House Bronx currently serves many members in a very high-need neighborhood in the Bronx. The Bronx has the highest prevalence of serious psychological distress in NYC, especially concentrated in the South Bronx. Bronx residents face higher rates of unemployment, challenges with poverty and numerous health disparities, including a critical lack of mental health services.

The Fountain House has help me through the toughest of times on the years of Eve. I lost my aunt, and came to the Clubhouse and help me with my lost. And they help me with my depressin ing days. I will come to the clubhouse because when I am feeling down they know what to do. I will run the morning and afternoon meetings ever day and I would raise everyone moods.

10 years ago, Fountain House expanded to have a clubhouse in the Bronx that has greatly impacted the lives of many Bronxites with SMI. But we have run out of space, so in order to continue reaching New Yorkers living with SMI, we need a larger clubhouse.

We have plans to expand that include developing a new 17,000 square foot clubhouse and a residential building with 30 studio apartments. The clubhouse will serve 4x the number of people currently served by the Bronx clubhouse and will provide lasting connections and membership for people for lifetimes and generations. We are eager to close service gaps in this mental health desert and would like to work with the Council to make this expansion a reality.

Thank you very much for reading this and for your consideration.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: MAR 4- 2023

(PLEASE PRINT)

Name: Assembly Woman Monique Chandler

Address: 40-Utica Ave Brooklyn NY 11203

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1021 Res. No. _____

☑ in favor ☐ in opposition

Date: 3/4/22

(PLEASE PRINT)

Name: Jayne Bigelsen

Address: 460 W 42 St

I represent: Covenant House NY

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☑ in opposition

Date: 4-5-2023

(PLEASE PRINT)

Name: Richard W. Flores

Address: —

I represent: —

Address: —

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Jordyn Rosenthal, Advocacy Coordinator

Address: _____

I represent: Community Access.

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. all Res. No. _____

☐ in favor ☐ in opposition

Date: 5/4/23

(PLEASE PRINT)

Name: Jayne Bigelsen

Address: _____

I represent: Covenant House NY

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. all Res. No. _____

☐ in favor ☐ in opposition

Date: 5/4/23

(PLEASE PRINT)

Name: Kimberly George

Address: _____

I represent: Project Guardianship

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. all Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Caitlin Garbo

Address: [redacted] Sterling Pl Brooklyn, NY 11216

I represent: NAMI-NYC

Address: 307 W 38th St. New York, NY 10018

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/4/23

(PLEASE PRINT)

Name: Cara Berkowitz

Address: _____

I represent: Coalition Behavioral Health

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. #0156-2022

☑ in favor ☐ in opposition

Date: 5/4/2023

(PLEASE PRINT)

Name: [redacted] Sarita Daftary

Address: [redacted] 40 Rector Street

I represent: Freedom Agenda

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 0156-2022

☑ in favor ☐ in opposition

Date: 5/4/23

(PLEASE PRINT)

Name: CASEY DALPORTO

Address: [redacted] BRIDGE ST BROOKLYN, NY 11201

I represent: NEW YORK COUNTY DEFENDER SERVICES

Address: 100 WILLIAM ST 20TH FLOOR, NYC 10038

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/4/23

(PLEASE PRINT)

Name: Kimberly Bourge

Address: _____

I represent: Project Guardianship

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. Multiple Res. No. _____

☐ in favor ☐ in opposition

Date: 5/4/23

(PLEASE PRINT)

Name: Alice Bufkin

Address: 14 Wall St 4E NY NY 10004

I represent: Citizens' Committee for Children

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. All Res. No. All

☑ in favor ☑ in opposition

Date: 5-4-23

(PLEASE PRINT)

Name: Ruth Lowenkron

Address: 151 W. 30th St., 11th Fl, NY, NY 10001

I represent: NY Lawyers for the Public Interest

Address: Same as above

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1006-2023 Res. No. _____

☒ in favor ☐ in opposition

Date: 5/4/23

(PLEASE PRINT)

Name: Lisa Furst

Address: 50 Broadway, 19th Fl NY NY 10004

I represent: Vibrant Emotional Health

Address: 50 Broadway, 19th Fl, NY, NY 10004

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/4/23

(PLEASE PRINT)

Name: Ava Rosenroth

Address: _____

I represent: The NY Foundling

Address: 590 Avenue of the Americas NY, NY, 10011

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/4/23

(PLEASE PRINT)

Name: Joelle Ballam-Schwan

Address: [redacted] Emmet Ave, Brooklyn, NY 11222

I represent: The Supportive Housing Network of NY

Address: 247 W 37th St, 15th Fl, NY, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Lasaundra Cannon (OCMHI)

Address: Acting Deputy Director

I represent: Mental Health (HMH) Systems

Address: and Initiatives

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Jamie Neckles

Address: Assistant Commissioner

I represent: of Mental Health (HMH)

Address: (DOHMH)

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Ashwin Commissioner Vasan (DOHMH)

Address: _____

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Deepa Arora

Address: Executive Deputy Commissioner of Mental Hygiene DOHMH

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ALC Res. No. _____

☐ in favor ☐ in opposition

Date: May 4, 2023

(PLEASE PRINT)

Name: Casey STARR

Address: Co-Executive Director

I represent: The Samaritans of New York

Address: Suicide Prevention Center

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ALL Res. No. _____

☑ in favor ☐ in opposition

Date: May 4, 2023

(PLEASE PRINT)

Name: Fiodhna O'Grady

Address: Director Government Relations

I represent: The Samaritans of New York Inc

Address: Suicide Prevention Center

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Daniel Skaggs, MD

Address: [redacted] Nancy St. [redacted] Brooklyn NY 11212

I represent: Fountain House, Member

Address: 425 W 47th St.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/4/23

(PLEASE PRINT)

Name: Ian Spens

Address: [redacted] 46th St. [redacted] Astoria, NY, 11103

I represent: Fountain House Clubhouse

Address: 425 W 47th St., New York, NY, 10036

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/4/23

(PLEASE PRINT)

Name: John Barrett John Barrett

Address: [redacted] EAST 165 ST Bx NY 10456

I represent: myself

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Nora Moran

Address: _____

I represent: United Neighborhood Houses

Address: 45 Broadway

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/4/23

(PLEASE PRINT)

Name: Lauren D'Esseth

Address: 315 2nd Ave

I represent: Community Access

Address: 315 2nd Ave

Please complete this card and return to the Sergeant-at-Arms