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Testimony of

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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]

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[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.

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[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]

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[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.

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[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.

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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.

3

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.

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]

• • 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.

- • 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.

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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
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RUTH LOWENKRON
JAMES MUTTON
HARVEY ROSENTHAL
CHRISTINA SPARROCK
PETER STASTNY
LAURA ZIEGLER

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