Human Resources Administration
Department of Social Services

Testimony of Daniel Tietz

The New York City Department of Social Services | Human Resources Administration

New York City Council General Welfare and Mental Health Committees

Oversight Hearing Part 2 – Behavioral Health Services in the DHS Shelter System

November 21, 2016

Good morning, Chairman Levin and Chairman Cohen, and distinguished members of the General Welfare and Health Committees. Thank you for inviting us to appear before you today to discuss behavioral health services in the DHS shelter system. My name is Daniel Tietz and I am the Chief Special Services Officer for the New York City Human Resources Administration (HRA) in the Department of Social Services, which also includes the Department of Homeless Services (DHS). Since the start of the 90-day review of DHS that was conducted earlier this year, I have assisted in the oversight of program services at DHS. I am joined today by my colleague, Fabienne Laraque, the DHS Medical Director who started in early September after a distinguished career at DOHMH.

From the start, this Administration has made unprecedented investments to address the very serious challenges faced by low-income New Yorkers, particularly the most vulnerable New Yorkers, many of whom are served by DSS. Notable among these challenges are the many problems that have built-up over more than two decades and which tend to drive the DHS shelter census higher: insufficient behavioral health programs, criminal justice system-involved individuals who are returning to New York City from prison, the loss of relatively inexpensive Single Room Occupancy (SRO) housing units, and a limited supply of available supportive and low-rent housing across the City. Taken together with long-term under-investments in truly affordable housing and flat incomes for hard-working families it becomes clear why one of the Administration's chief priorities has been reducing income inequality and leveling the playing field for all New Yorkers.

From its inception, this Administration has recognized and directly addressed these challenges through multiple historic investments to break the trajectory of homelessness, which has increased 115% since 1994, and exponentially from 2011 into 2014 when there were no rental assistance programs in place to address homelessness after the Advantage program was ended by the City and State.

- Beginning in late 2014, the Administration announced the creation of the Living in Communities (LINC) rental subsidies and since has expanded the availability of **rental**

assistance to support New Yorkers who qualify for assistance in order to remain stably housed.

- In June 2015, the Administration created the **Three-Quarter Housing Task Force**, bringing together representatives across city agencies to address a long-ignored problem thereby shining a light on an unregulated segment of the low-income housing market whose operators prey on New Yorkers in need of services and support as they transition to independence and self-sufficiency.
- Almost exactly one year ago today, Mayor de Blasio made a historic announcement concerning **Supportive Housing**, investing in 15,000 City-funded units over the next 15 years with the first 500 to be awarded shortly. We know from evidence-based research that supportive housing programs help reduce the use of shelters, hospitals, and psychiatric centers, reduce chronic homelessness, and improve stability.
- In December of 2015, prior to the completion of the 90-day review, the Mayor announced **HOME-STAT (Homeless Outreach & Mobile Engagement Street Action Team)**, a first-of-its-kind in the nation response to addressing street homelessness, and by April, the program was fully operational.
- **Safe Haven Beds** are an essential tool in assisting outreach workers in bringing our street homeless off the streets and into services. These individuals are the most vulnerable and hard to reach homeless New Yorkers and require ongoing and lower threshold engagement. To date, the City has opened 225 Safe Haven beds increasing the total to 752 beds, with more to come. There are also 357 stabilization beds to help bring New Yorkers in from the streets.
- **Cluster take-down**: to date, the City has discontinued the use of 250 cluster units and identified another 295 to be closed soon. This 16-year approach of removing affordable apartments from the housing stock and using them as shelter subjected families to fractured social services, challenges on their path towards independent living, and led to disrupted communities.
- **ThriveNYC,** launched earlier this year, is an extraordinary $850 million investment over the next four years aimed at transforming the way we address the mental health needs of New Yorkers. This initiative is not only aimed at homeless New Yorkers, but all City residents who struggle with mental illness or are affected by a loved one's experience.

No New Yorker should suffer homelessness, and no one with a mental health problem should become homeless because of such an illness. Unfortunately, many people with behavioral health needs become homeless because it affects their ability to maintain employment, housing, or healthy relationships. To get at the root of this problem, we have embarked on a mission to transform the way we address mental health needs in New York City.

ThriveNYC is an action plan to change the way our city thinks about mental health and substance use disorders, and the way the City delivers services. Through ThriveNYC, we have increased the behavioral health workforce, developed innovative, cross-agency program models, and expanded crisis services for all New Yorkers.

It is important to acknowledge that no one became homeless overnight because of an illness. For homeless individuals with serious mental illness, there were numerous points in their life when they were not able to get the help they needed, when the system broke down. No illness should result in homelessness and, therefore, everyone needs a system where care is accessible.

Each of these actions taken alone is important, but together they represent a commitment by this Administration to tackle the very difficult challenges faced by low-income and working-class New Yorkers and that have received far too little attention for far too many years. Likewise, it will take time for our solutions to have a full and lasting impact and we will need the help and support of all, including this Council and our state and federal partners.

In my testimony today, I will provide a summary overview of the DHS system – which provides temporary and transitional housing, and serves as a place of last resort for those in need of shelter. I will focus much of my testimony on updating the committees on the progress of relevant and substantial reforms stemming from the completion of the 90-day review of the homeless services system in New York City. I will close with a more specific overview of the programs and services for families with children, as well as for single adults and adult families, to address clients' behavioral health needs while in shelter and the associated outcomes.

Last week, in Part 1 of this hearing, I provided some context and noted several ways in which HRA and DHS work closely to serve our shared constituents, taking a prevention-first approach. To summarize:

- Homebase, which had been administered by DHS has been moved to HRA.
- Over the past two years, the new rental assistance programs and other permanent housing efforts have enabled 47,810 children and adults in 17,094 households to avert entry into or to move from DHS and HRA shelters.
- January 2014 through June 2016, about 131,000 households – including approximately 390,000 people – received emergency rental assistance to help them stay in their homes, averaging about $3,600 per case, which is much less than the $41,000 it costs each year to shelter a family.
- This Administration has increased funding for legal services to prevent evictions, harassment, and homelessness 10-fold, from $6.4 million in FY2013 to $63.8 million in FY17 when the program is fully implemented.

- There has been a 24% decrease in evictions by City marshals over the past two years and an increase in legal representation of tenants in Housing Court from 1% as reported by the State Office of Court Administration for 2013 to 27% this year.

As was noted last week, and is worth repeating, those most at risk of homelessness are affected by high rates of poverty, family conflict and domestic violence, as well as poor health, including high rates of chronic disease and behavioral health diagnoses, coupled with low access to care. At DHS intake points, clients arrive with a host of complex and interrelated challenges, but have one thing in common: a lack of safe and affordable permanent housing. It is both our legal and moral obligation to shelter those New Yorkers who are found to be eligible for and in need of shelter.

As of November 19, 2016, DHS is sheltering 60,318 individuals, including:

- 23,657 children
- 36,661 adults

These individuals and families are housed across DHS's system of facilities for single adults, adult families with no minor children, and families with minor children utilizing shelters, cluster units, and commercial hotels. Among the facilities that constitute the DHS portfolio, 47 single adult shelters and 23 families with children shelters have access to on-site health care. We also operate a number of specialized shelters, including 27 mental health shelters; nine substance use disorder shelters; plus 14 safe havens and five drop-in centers.

I refer the committees to my testimony of November 17, 2016 in regards to the shelter intake process and the medical and behavioral health screenings that take place at the front door of shelter.

I will now describe details of the ongoing reforms most relevant to this hearing that were identified as part of the 90-day review of homeless services and which have been implemented since the announcement of the review.

REFORMS

1. **Target services and rental assistance for clients with mental health needs cycling between jail and homelessness:** City rental assistance will be strategically targeted to identified at-risk clients with mental health needs cycling between Rikers Island and DHS shelters. DHS is working on this initiative with MOCJ and we look forward to continuing to update the Council on our progress in addressing the needs of these clients.

2. **Fully launch HOME-STAT to address street homelessness:** HOME-STAT is a first-of-its-kind approach to allow us to better understand and address the City's street homeless population. This initiative partners existing homeless response and prevention programs with a series of new innovations designed to better identify, engage, and transition homeless New Yorkers from the streets to low threshold engagement and support services, as well as permanent housing.

   This reform initiative began prior to the completion of the 90-day review and fully operational in April of this year. This innovative program is the most comprehensive street homelessness outreach effort ever deployed in a major American city. HOME-STAT innovates by partnering homeless response/prevention programs and by using modern technology such a mobile application and 311 services to more accurately identify, engage, and transition homeless New Yorkers from the streets to services. Additionally, by conducting more frequent, quarterly counts, the last having been completed in the overnight hours of November 6, 2016, we are able to more closely track our efforts and evaluate our approaches to better tailor solutions to the visible problem of street homelessness.

   With nearly 500 workers to help transition homeless individuals from the streets and into shelters, HOME-STAT is enabling the City to better address the needs of New Yorkers who are living on the streets. Canvassing conducted by the Mayor's Office of Operations has increased our ability to identify street homeless individuals from Canal Street to 145th Street and in other hot spots, and deploy outreach resources where they are needed most.

   With HOME-STAT the contracted homeless outreach staff grew from 195 to approximately 385. Additionally, the NYPD redeployed 40 officers to its 70-officer Homeless Outreach Unit to respond to calls concerning street homeless persons, encampments, large hot spots and those individuals experiencing emotional disturbances or exhibiting erratic behavior.

   Additionally, we enhanced funding for additional safe haven beds, and three more drop-in centers.

   Drop-in centers provide a low-threshold alternative to traditional shelter for street homeless individuals and offer temporary respite where individuals can shower, eat a meal, see a doctor, and rest. There is on-site case management and housing placement services, as well as a limited number of off-site overnight respite beds.

   The City announced a new $8.5 million annual commitment to double the number of drop-in centers it currently operates. DHS will open three new drop-in centers and fund the current HUD-funded drop-in center in the Bronx, which is operated by BronxWorks, as HUD looks to reinvest those dollars in permanent housing. These four locations will be added to

the four existing City-funded centers: two in Manhattan, one in Staten Island and one in Brooklyn. The new centers will open in Manhattan, Brooklyn and Queens, serving approximately 75 clients each at any given time.

These tools are important in creating a low-threshold option to serve as an initial link to DHS programs and services as part of our intensive effort to persuade street homeless individuals to engage in services and ultimately accept permanent housing.

All of these initiatives to address street homelessness recognize that the pathway to the streets was not linear for these individuals and the path from the street likely won't be either. Therefore, a one-size-fits-all approach is unlikely to work. All HOME-STAT agencies play a role in this effort, including DHS, HRA, NYPD, other health, housing and human services providers.

DHS would also like to remind caring New Yorkers to help us help homeless New Yorkers by calling 311 if they see a homeless person on the street or in the subway so that an outreach team can be deployed. This can also be done by accessing the 311 website.

3. **Enhance tools for outreach teams to bring people in from the streets:** The City will increase safe haven beds, increase the number of drop-in centers, and develop 15,000 units of supportive housing to provide essential tools to address street homelessness.

   As described earlier in my testimony, progress on these reforms is well underway and we continue to ask the City Council to partner with DHS in order to site not only safe haven beds, borough-specific drop-in centers, and supportive housing, but also necessary purpose-built shelters for families with minor children, adult families, and single adults. Homelessness is a citywide problem and we each have a role to play in securing effective solutions. As such, good, purpose-built shelter ensures greater impact and better helps families to more quickly transition to permanent housing and independence.

4. **Targeting services for emerging new trends in the single adult population (persons 50 or older and 18 to 24):** More effective targeting will promote our prevention and rehousing efforts. For example, in partnership with Council Member Ritchie Torres, we announced last Friday the first-of-its-kind shelter in the DHS system targeting young adult LGBTQI homeless New Yorkers. DHS's ability to respond to emerging trends in the single adult population allow us to better serve our clients and more quickly move them to independence through targeted supports.

   Additionally, DYCD is expanding its runaway and homeless youth beds and working closely with DHS and DSS to improve coordination and services for youth who come to DHS shelters.

I should also note that for older adults, in partnership with HPD and DFTA, HRA recently released a senior affordable housing concept paper. The concept paper focused on receiving comments about the most appropriate services to support seniors living in independent housing. An RFP will soon follow.

5. **Implement a more effective aftercare program:** Using the critical time intervention as a model, the City will enhance aftercare services for rehoused clients.

   DSS released a concept paper in late October with the goal of expanding and re-aligning services at Homebase such that HRA staff can provide additional on-site processing and triage for HRA benefits, including public assistance and rental assistance, and Homebase not-for-profit staff can expand their case management services to include landlord and family mediation, educational advancement, employment, and financial literacy services. Additionally, we intend to provide enhanced community support services for residents receiving rental assistance to help ensure that they do not return to shelter and will remain housed in the community. Comments on the concept paper are due December 14, 2016 and an RFP will be issued shortly thereafter.

6. **Provide assistance to obtain federal disability benefits:** The City will dedicate services to focus on enrolling shelter residents on SSI/SSD to increase income and promote rehousing.

   We are expanding legal services to help clients obtain disability benefits and we continue to focus on ensuring that New Yorkers who are eligible for benefits and services are linked to the same. DSS is actively exploring ways in which we can reduce barriers to access benefits and promptly link eligible clients to benefits. We are making critical improvements to ACCESS NYC, the city's one-stop, online benefits tool that screens individuals for over 30 benefits as well as an online portal so that a client can obtain information about their benefits in real time.

I will now focus on several core programs at DHS that serve clients with behavioral health diagnoses.

SERVICES ACROSS THE DHS SYSTEM

Assessment and Screening for FWC

As I testified on November 17, 2016, many families have existing medical and mental health care providers upon arrival at the Prevention Assistance and Temporary Housing (PATH) center, and thus not all families are referred to the on-site medical provider for comprehensive assessments. At PATH, each woman of childbearing age in the family is asked about pregnancy, the presence of an infant under four months of age, any hospitalization in the past month, any

acute medical needs, or the presence of a communicable disease. If any of these are present, the family is referred to The Floating Hospital, which is the on-site clinical provider. In addition, families self-reporting or observed to be facing mental health or substance use challenges are referred to DHS Resource Room Social Workers for further assessment. As part of our reform process, the DHS Medical Director's Office, in collaboration with HRA and DOHMH, is reviewing which questions families are asked in order to best address immediate medical and behavioral health needs in the intake process; setting standards for behavioral health services at intake points; crafting oversight tools; and implementing the oversight and evaluation processes.

Completion of Mental Health Assessment by Resource Room and The Floating Hospital

Resource Room Social Workers complete mental health and substance use assessments in the DHS CARES system, including a history of symptoms and treatment and a risk assessment to determine orientation to time, place, and person; the potential presence of auditory and/or visual hallucinations; and any intent and/or plan to harm self or others. Assessment findings determine whether or not a call will be placed to 911 for EMS assistance and possible hospitalization. The emergency protocol, including calling 911 or presenting at the closest emergency room in the event of a psychiatric emergency, is reviewed with families. Available community-based services are also discussed with presenting families, including 1-800-LIFENET.

Families identified with behavioral health needs not currently receiving treatment services are scheduled to meet with The Floating Hospital's psychiatrist who is stationed at PATH on Wednesdays from 10am to 6pm. The psychiatrist completes a comprehensive mental health evaluation (which is maintained in The Floating Hospital's electronic medical record). Families identified with mental health or substance use concerns that are currently receiving treatment are also given the opportunity to present supporting documentation from their treating clinician. The findings of these evaluations are reviewed by a Social Work Supervisor or Manager in conjunction with the prior or preliminary shelter eligibility determination with recommendations for final eligibility made after full consideration of the client's behavioral health needs.

If service needs are identified and services are not in place, the Resource Room Social Worker will discuss available options with the family and will provide support during their conditional stay, ensuring shelter staff are aware of the presenting issues and that necessary services are maintained or commenced.

Within the FWC system, the Clinical Services Unit launched in the winter of 2015 to address the particular needs of families and consists of a team of social workers who work across the FWC shelter system; please reference my November 17 testimony for additional detail.

Social Worker in Shelter - Demonstration Project

In order to improve access to mental health services in FWC shelters, to improve family functioning, and to assist families with children in shelter as they navigate multiple systems and cope with the stressors and anxiety that are induced by homelessness, DHS is developing a plan to place 368 Licensed Masters' of Social Work staff in shelters for families with children. These LMSWs would serve as Client Care Coordinators.

DHS and DSS are working with State OTDA on approval of the demonstration project plan and budget such that the new Client Care Coordinator positions as part of the standard FWC budget. This will facilitate the rollout of the plan and ensure that shelter providers are able to expeditiously hire these LMSWs.

Through the use of these LMSW Client Care Coordinators, DHS will vastly enhance the delivery and coordination of mental health and related services to FWC in shelter, promote and model best practices for shelter social services and case management staff, improve linkages to mental health and community-based services, increase the ability of shelter social service staff to address mental health needs in a culturally and linguistically sensitive manner that incorporates strength-based, family-driven, and youth/child-guided care, and strengthen overall permanency outcomes for families with children in shelter.

Adults

Psychiatric Evaluation at Assessment Shelters

After intake, all adults admitted to the shelter system are sent to an assessment shelter where providers conduct a comprehensive assessment including history and physical, brief psychiatric assessment, and substance use assessment. The brief psychiatric assessment includes any presenting complaint, history of present illness, past psychiatric history, substance use history, medications, family and social history, and a full mental status examination. The assessment is completed within five and ten days of the client's arrival. This assessment is used to direct new entrants into the DHS system toward either a general or mental health or substance use shelter. These shelters provide specialized services on-site as well as linkage to an array of outpatient mental health services, as described below.

Assisted Outpatient Treatment (AOT), in 1999 New York State enacted legislation that allows for mandated outpatient treatment by court order for persons with mental illness who are unable or unwilling to follow clinical guidance and treatment. This service, call Assisted Outpatient Treatment or AOT, mandates mental health care for a period of up to six months, which can be extended once.

Whether after an AOT order or voluntarily, the following outpatient services are available to DHS clients with mental health issues.

Care Coordination:

A specially trained individual or team that helps clients better understand and manage their conditions, works with clients to create a plan of care that meets their physical, mental health and social service needs and assists the client in finding the services and programs that are right for their needs.

Assertive Community Treatment (ACT):

ACT is an evidence-based practice model that provides treatment, rehabilitation and support to individuals diagnosed with a severe mental illness and whose needs have not been well met by more traditional mental health services. The ACT team provides services that are tailored to each client's specific needs. ACT teams are multi-disciplinary and include psychiatry, nursing, psychology, social work, substance use counseling, and vocational rehabilitation. Team members collaborate to deliver integrated services to the client. Specialized ACT teams are being trained to reach and serve people who are chronically homeless.

Intensive Mobile Treatment (IMT):

IMT is a specialized team that provides intensive and non-billable treatment in settings that are convenient to clients who may be unstable. The teams are designed to keep clients in treatment, even if they are in an unstable situation, such as cycling from jail to street and shelter or face housing instability.

Co-response Teams:

The co-response teams are specially trained NYPD officers with embedded DOHMH clinicians that can more effectively respond to and triage individuals a serious mental illness and about whom we have great concern regarding potential violent behavior.

DHS and DOHMH collaborate to identify AOT clients in DHS facilities via a monthly data match. Each shelter operator is alerted to individuals with AOT orders residing in shelter and efforts are made to transfer AOT clients to mental health shelters, if necessary, to better ensure their continued connection to mental health treatment providers, and to more quickly place them in appropriate permanent housing. In addition, contracted clinical providers may refer to or request AOT services for their clients who meet the criteria.

In CY15 there were 239 individuals with AOT orders in DHS shelter.

Mobile Crisis Teams are an interdisciplinary team of mental health professionals, including nurses, social workers, psychiatrists, psychologists, mental health technicians, addiction specialists, and peer counselors. These teams operate under the auspices of voluntary agencies and municipal hospitals, responding to persons in the community, usually visiting them at home, although their mandate allows them to make contact at other locations.

Mobile crisis teams serve any person in New York City who is experiencing or is at risk of a psychological crisis and who requires mental health intervention and follow-up support to overcome resistance to treatment. Mobile crisis teams are often called by family members, neighbors, friends, landlords, clergy, or other person(s) concerned about an individual.

Mobile Crisis Team staff provide a range of services including assessment, crisis intervention, supportive counseling, information and referrals, linkage with appropriate community-based mental health services for ongoing treatment, and follow-up.

Often the assistance of a mobile crisis team is requested for a person identified as homeless. In such instances, the teams contact DHS to verify the homeless person's location within DHS. To ensure full collaboration, the DHS Medical Director's Office promptly alerts the shelter to a mobile crisis team's imminent arrival to evaluate the client.

In CY15, there were 246 mobile crisis team referrals for shelter residents.

Naloxone in Shelters

Drug overdose is a serious public health concern and opioid-related overdoses have increased as a health threat. A life-saving law took effect on April 1, 2006, making it legal in New York State for non-medical persons to administer naloxone to another individual to prevent an opioid/heroin overdose from becoming fatal. Naloxone (Narcan) is a medicine that reverses an overdose by blocking heroin or other opioids in the nervous system for 30 to 90 minutes. In shelters, naloxone is administered intra-nasally.

The DHS Medical Director's Office began training shelter staff as certified Opioid Overdose Responders in 2009. To date, all DHS Peace Officers are trained in naloxone administration and are certified Opioid Overdose Responders. DHS Peace Officers administer naloxone in DHS directly-operated shelters and in contracted shelters where they are stationed. DHS has also been working with all contracted shelters so that they become Opioid Overdose Prevention Programs (OOPP), and many contracted shelters now have their own OOPP's and train their staff. Since 2009, 1,193 Peace Officers and 2,787 shelter staff have been trained to become certified responders.

Our immediate goal is to train shelter staff and some residents at all directly-operated and contracted shelters as Opioid Overdose Responders in 90 minute sessions offered over several days by the end of this calendar year thereby ensuring enough staff are trained to offer 24/7 coverage in every shelter. This will be done by training a select number of shelter staff as trainers who will in turn train other staff at their shelters. In addition, we are providing naloxone administration kits to every shelter to be kept in an easily accessible central location at the shelter to which trained staff shall have access.

To date, we conducted a survey to identify those shelters in need of naloxone training. All adult family and FWC shelters that require it will obtain training and certification by the end of 2016. Most single adult shelters already have fully trained and certified staff, as do all of the street outreach programs; the remainder will also be required to participate in training and will receive naloxone kits by the end of the calendar year. In addition, NYU medical students have been training clients at the 30th Street shelter.

By ensuring widespread availability of naloxone training, certification and kits among shelter staff, including having staff able to train others at their shelter, as well as some residents, we expect to significantly reduce the incidence of overdoses and OD deaths. In calendar year 2016 (to date), there were 79 naloxone administrations with 66 lives saved and 13 deaths after an attempted reversal.

Chronic Public Inebriates Pilot

The chronic public inebriate pilot program is a joint initiative of Bellevue Hospital Center, DHS, and the Goddard Riverside Community Center. Bellevue identified the most frequent emergency department users who were thought to be street homeless and had been diagnosed with at least one alcohol-related disorder during an emergency department visit. With the patient's consent, the hospital and DHS Outreach Teams provide case management and help place the individual in a stabilization bed or safe haven. The ultimate goal is permanent housing placement, thus improving each client's health and decreasing the risk of death. Preliminary data from the pilot show a 38% and 35% reduction in hospital emergency department visits and in-patient days, respectively, as well as a reduction in associated costs for individuals enrolled in the program. The majority of program participants (79%; 19 of 24) are in transitional or permanent housing. DHS recently expanded this program to two additional NYC hospitals, St. Barnabas and Lincoln Hospitals in the Bronx.

Retraining and Security Action Plan

The NYPD assigned a management team to be placed at DHS and developed an action plan to upgrade security at all shelters. The NYPD also retrained all DHS security staff. Currently all non-cluster shelters have some level of security provided by either DHS Peace Officers or by private

security guards. And as part of the 90-day review, security was increased at mental health shelters and commercial hotels.

This Administration has substantially increased spending for security at homeless shelters. Direct spending by DHS on DHS peace officers and contracted FJC security guards has increased 63% from $48 million in FY 2013 to $78 million in FY 2016. In addition, DHS reimburses shelter providers for their security costs, which was $62 million in FY 16, for total of $140 million in security costs.

I would now like to respond to the bill before this committee, Intro. 932, which would require the Department of Homeless Services to submit to the Council and post on its website annually a report containing information on mental health services provided to individuals in shelter. We support the intent of this legislation and agree with this body on the importance of reporting to promote transparency and accountability. We welcome working with the Council on potential modifications in order to develop reporting metrics that will be clear and useful, and which will accurately capture the work of DHS as it relates to mental health care services in shelter.

Thank you for the opportunity to testify today and to respond to the bills before each committee. We welcome your questions.

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Dr Bouchard-Burns became board certified in Internal Medicine, Psychiatry and Addiction Medicine. He has been practicing as a Psychiatrist and Addiction Specialist since his residency program selected him to work with the "difficult populations of the homeless". He has been working since then with the homeless of NYC.

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November 21, 2016
NYU LUTHERAN FAMILY HEALTH CENTERS
Prime Sponsor: Corey Johnson - Chair of Committee on Health
Committee on General Welfare, Committee on Health
Chair of Committee on General Welfare: Stephen Levin

Good morning Chairperson Levin, Chairperson Johnson, members of the General Welfare and Health Committees, members of the City Council, Department of Homeless Services, and colleagues. Thank you for the opportunity to speak today.

I am Dr. Bouchard-Burns, Psychiatrist and Behavioral Health Director with the NYU Lutheran Family Health Centers' Community Medicine Program. I have been working for the homeless of NYC since 2000. I have worked in assessment shelters including the largest single men's assessment shelter at 30th Street, shelters that house mentally ill and chemically addicted men and women, shelters that house the medically frail, shelters for the working poor, and single room occupancy sites.

I come here today with 17 years in the trenches and thousands of conversations with some of New York's most vulnerable fellow human beings.

I can testify that the shelters and the people we treat are facing many Mental Health problems, and that these problems are often not adequately addressed. In reality, we don't even know how large the gap is between disease and treatment because data is sparse and disjointed. Though each shelter provider collects data, we don't have ongoing and comprehensive reports on the health and mental health of the homeless we shelter in New York City.

Increased data collection and reporting are first steps to understanding the nature and scale of problems facing the shelter system, and as such NYU Lutheran Family Health Centers' Community Medicine Program strongly supports the bill proposed by Councilmen Levin and Corey. We commend you for taking the initiative.

Today I would like to address three issues that impact the mental health of the homeless. One is that homelessness is often the result of pre-existing mental illness, and that homelessness itself can initiate or aggravate mental illness. Two, the current shelter system structure makes it very hard to maintain good mental health. Third, mental health services provided inside the shelters are critical to mitigating the impact

of mental illness until people return to the community, but a rapid return to housing creates the conditions that can stabilize mental health.

People experiencing homelessness represent a diverse group of people. Some are temporarily homeless. Perhaps they lost their job or a family member got sick and the medical bills meant that they could no longer pay rent.

Others are homeless for years, many of whom have histories of trauma. Trauma is known to change how the brain functions. People cope with their histories in different ways, including using drugs to dull their pain.

I have treated patients living with schizophrenia, bipolar disease, personality disorders, chronic and profound depression, anxiety disorders, and addiction to a whole range of substances. I have heard stories that are hair-raising. My patients' illnesses often made it hard for them to sustain jobs and interpersonal relationships. Their illnesses led them to homelessness.

And homelessness itself is often traumatic. On the streets and in the shelters, there is violence, drug use, bullying, poor quality and insufficient food, sleep deprivation, poor access to healthcare and abundant loneliness.

Whether people come to be homeless because of mental illness and drug use, or become mentally ill and drug addicted because of homelessness, the reality is that there is a large overlap between the two and that all programs for the homeless must promote mental health and treat mental illness.

Which brings me to the second point, that the shelter system makes it difficult to maintain mental health.

Typically when you enter the shelter system you have nothing: no family, no friends, no money, no spare clothing, *and no hope*.

Immediately, you encounter inadequately trained and poorly paid staff, the majority of whom are therefore not sensitive to your situation, and are even hostile. Whether intentionally or not, they degrade and further aggravate your trauma.

Guards treat you like a criminal. They are desensitized themselves after being exposed to the pain of homelessness and a dysfunctional system on a daily basis.

You are given a room with countless others, sometimes 20-40 other people, and are left alone at night to fend for yourself. It is not uncommon for fights to break out. Darwinism is real here. The strongest prevail and dominate.

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The rules are not of civility but of power. Patrols are inadequate; shelter residents do not feel safe.

You get little sleep because someone wants the lights on, plays music, stinks, or smokes crack/K2.

The bathrooms are dirty.

Every morning you are forced to leave the dorm and either go to a waiting room where different prison-like dynamics play out, or leave the shelter. You cannot catch up on lost sleep.

You are fed food that ex-convicts have told me is better in prison.

Anger and frustration set in and conflict between residents is rampant.

Exposed daily to this chaos, shelter staff themselves burn out, are triggered, and tire. They direct their frustration and anger at you.

Where is the support? Where is the peaceful environment where healing can take place? Why are the shelters not on par with the homes you and I go to every night? Where is the warm hand off to the Medical and Mental Health Staff that can facilitate your journey out? How can you find hope?

Much to Mayor De Blasio's credit, he has recognized and funded mental health initiatives to address mental health supports in shelters, as well as to train staff in trauma informed care. But more is needed, urgently. Not just clinical services, but environments that can sustain stability.

Third, mental health services in the shelters can provide essential services to bridge care, stabilize and strengthen people's mental health. We have psychiatric Nurse Practitioners, social workers, drug abuse counselors and navigators that provide therapy, that prescribe and manage medications, and that provide linkages to physical health care. We have providers who regularly save lives with NARCAN when someone has overdosed. Though these are crucial to providing acute and transitional care, we cannot delude ourselves into thinking that this is enough. Every year we hold a memorial for those who died in the past year. Every year I am stunned by the premature deaths caused by poor access to healthcare but most importantly caused by an absence of those elements that make life worth living: a home, loved ones, joy. We know because of published research that housing first is critical. Housing is a health intervention in and of itself.

We understand that much of what would make the homeless well are long-term goals such as affordable housing and integrated care. We must continue to advocate fiercely for those.

And we also think that there are short-term fixes that could make a profound difference:

1. Primary care and mental health screening should be mandatory, and shelter clients should be encouraged to attend their follow-ups. Such screenings should be part of contracts with DHS.

NYU Lutheran
NYU LANGONE
HEALTH SYSTEM
Community Medicine Program

2. Measures of the implementation of trauma-informed care should be part of this bill's data tracking system. The City's efforts to roll out trauma-informed trainings for staff are commendable first steps. These efforts must continue and include shelter-based observation and coaching of staff working in shelters.

3. The city should promote a complaint-line where shelter patients can place complaints and have their concerns addressed without fear of retribution. Currently, abuses by staff are not taken seriously and clients do not have an avenue where their complaints can be reported, investigated, and addressed. Clients are inappropriately villanized if they speak out against the injustices they encounter in the system. Some are even sent to the ER for complaining.

People who are homeless are human beings. For too long, homeless people have been looked upon as some type of aberration - not a part of society. We must acknowledge that people fall on hard times and homelessness is a part of the ebb and flow of human existence.

Our vision is that of a homeless system that not only shelters but also nurtures people to reach their potential. We envision a shelter as a place where someone can find temporary respite and regain their footing and - for the majority of people - proceed with becoming the contributing member of society that they once were, or will become for the first time. Of course, there are those that find themselves in the unfortunate situation of not being able to achieve this goal, and we need to provide avenues for these people to live a fruitful and satisfying existence.

We look forward to the annual reporting that this bill will mandate, and encourage the bill to measure efforts of mental health promotion as it could allow us to more accurately understand the situation and allow for better distribution and implementation of services.

We at the NYU Lutheran Family Health Centers' Community Medicine Program ask for this bill to be passed.

Thank you.

NYU Lutheran Family Health Centers / Community Medicine Program
Barbara S. Kleiman Residence, 300 Skillman Avenue, Brooklyn, NY 11211 , tel 718.302.7366 , fax 718.486.6296
Administrative Services 5th Floor / Clinic 1st Floor

Testimony of

Chad H. Gholizadeh
Senior Policy and Advocacy Associate for
Economic and Housing Stability

Before the

New York City Council
Committee on General Welfare

Oversight Hearing:

Mental Health Services in the DHS Shelter System

Int. 0932-2015 requiring the Department of Homeless Services to provide the City Council and to post on its website an annual report regarding mental health services provided to individuals and families in the shelter system

November 21, 2016

Good morning. My name is Chad H. Gholizadeh and I am the Senior Policy and Advocacy Associate for Economic and Housing Stability at Citizens' Committee for Children (CCC). CCC is a 73-year-old independent, multi-issue child advocacy organization dedicated to ensuring every New York child is healthy, housed, educated and safe.

We would first like to thank City Council Chairs Stephen Levin and Mark Levine, as well as all of the members of the Committees on General Welfare and Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability for holding today's oversight hearing on the mental health services the Department of Homeless Services (DHS) in the DHS shelter system.

We would also like to Council Member Levin, and the bill's co-sponsors, for introducing Int. 932-2015, which would require DHS to publish an annual report regarding mental health services provided to homeless individuals, parents and children in the shelter system, as well as the unsheltered homeless population.

New York City is facing a nearly unprecedented rise in homelessness. As of November 16, 2016, there were 60,667 individuals were in the DHS shelter system.[1] Nearly 24,000 of these people are children from just over 13,000 families.[2] The 41,957 adults and children living in DHS's shelters for families with children make up nearly 70% of the DHS shelter system.[3]

In addition, the most recent data available (from September 2016) shows there were 964 families with children (with 1,657 children) living in HRA Domestic Violence shelters and 23 families with children (23 adults and 48 children living in DYCD shelters.[4] In addition, even in the DHS shelter system, domestic violence is one of the main reasons families are entering shelter.[5]

Not only do families with children make up the majority of shelter residents, but according to the most recent Mayor's Management Report, their average length of stay in shelter is 431 days- well over a year.[6]

It is worth noting that the combination of the long length of stay, the increasing number of families coming into shelter, and the lack of available Tier 2 shelter capacity has led to an increased use of cluster sites and commercial hotels, despite the administration's desire to phase out the use of cluster sites, let alone stop using hotels. A recent report by Comptroller Stringer

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[1] NYC Department of Homeless Services Daily Report 11/17/16. http://www1.nyc.gov/assets/dhs/downloads/pdf/dailyreport.pdf

[2] Id. On November 16, 2016, there were 13,207 families in the DHS shelter system with 23,813 children.

[3] Id. As of November 16, 2016, the adults and children in the families with children shelters were 69% of all those in DHS shelters.

[4] Local Law 37 Report for the Month of September 2016 (available at https://www1.nyc.gov/assets/operations/downloads/pdf/temporary_housing_report.pdf).

[5] Rosa Goldensohn and Gerald Schifman, "Domestic violence emerges as economic scourge and primary driver of homelessness," Crain's New York Business, October 26, 2016 (available at http://www.crainsnewyork.com/article/20161026/BLOGS04/161029881/domestic-violence-emerges-as-primary-driver-of-homelessness-in-new#utm_medium=email&utm_source=cnyb-realestate&utm_campaign=cnyb-realestate-20161027).

[6] New York City Mayor's Management Report Fiscal Year 2016. http://www1.nyc.gov/assets/operations/downloads/pdf/mmr2016/dhs.pdf .

found that there were almost 3,735 families placed in commercial hotels.[7] It is important to note that most cluster sites and hotels have few, if any, on-site services.

Housing instability and homelessness cause stress and trauma for families and children. The exposure of a record number of families to the traumas of homelessness is part of a multi-generational cycle that has a demonstrated negative impact on the educational and mental health outcomes of children.[8] It is therefore critical that as a City we take measures to ensure programs and services are available to address the needs of these vulnerable families and that the shelter system does not exacerbate or contribute to the trauma of families seeking those services.

Given the historic levels of homelessness and the challenges homeless children and their families have been facing, we are pleased that the de Blasio administration has begun to make some efforts to address the challenges families in the shelter system face, including those relating to mental health. As part of its ThriveNYC initiative, the City has committed to placing licensed clinical social workers as client care coordinators in all 72 contracted family shelters,[9] and complete a survey of mental health services available in school.[10] The mayor also included funding in the FY2017 Budget to hire 33 social workers to work in the 43 schools with the highest populations of students residing in shelters.

Homelessness is a traumatic experience for both adults and children, and the shelter system must be designed not only to meet the needs of families coping with trauma but to not inflict additional trauma and emotional distress. Homeless families face many challenges when attempting to maintain their well-being. Homelessness, particularly when families are placed far from their communities, schools, friends, service providers and support systems, often disrupts children's schooling, disconnects families from their communities and services, and makes it more difficult for adults to maintain gainful employment. It is important that the shelter system itself operate in a trauma-informed manner and be able to provide swift access to mental health services when they are needed.

CCC respectfully submits the following recommendations to better address mental health needs of children and parents living in New York City's shelter system:

1. Improve Shelter Capacity and Conditions

Families housed in unsafe, unsanitary, or overcrowded conditions face additional barriers that can negatively impact their mental health. As a first step to helping families coping with the already traumatic experience of homelessness, the City and DHS must avoid causing further trauma by providing them with safe and appropriate shelter during their stay.

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[7] NYC Comptroller Scott Stringer. *An Investigation into the Provision of Child Care Services in New York City Homeless Shelters*, p. 20 (available at http://comptroller.nyc.gov/wp-content/uploads/documents/Homeless-Child-Care-Report_October.pdf).

[8] The Forgotten Face of Homelessness, p. 18-19 (available at http://winnyc.org/wp-content/uploads/2016/10/forgotten_face_whitepaper_FINAL.pdf).

[9] ThriveNYC: A Mental Health Roadmap for All, p. 53 (available at https://thrivenyc.cityofnewyork.us/wp-content/uploads/2016/03/ThriveNYC.pdf).

[10] ThriveNYC: 150-Day Update, p. 17 (available at https://thrivenyc.cityofnewyork.us/wp-content/uploads/2016/06/Thrive150_report_fnl_singlepages.pdf).

a. Eliminate the Use of Cluster Sites and Commercial Hotels

The expansion of cluster site shelters and commercial hotels are the unfortunate result of New York City's record homelessness. Families placed at these sites, who need access to services ranging from housing assistance to job readiness training to mental health services must often not only receive the services themselves offsite, but even the case management and referrals are typically offsite. This poses additional obstacles for those homeless families working long or irregular hours, or who must accompany their children on long commutes to their schools.

The number of families with children sheltered in commercial hotels has increased precipitously, from zero people in 2015 to 3,735 people in August 2016.[11] In addition to the problems associated with housing families for long periods of time in a service-poor site that often lacks cooking and laundry facilities, the use of commercial hotels is more expensive than other types of shelter.[12]

Thus, not only do these sites typically lack the services that would help address mental health needs, placing children and their families in these types of shelters might also create mental health issues for families.

While the plan released with the 90-day review includes phasing out cluster sites over the next three years, we urge the administration to expedite this timeline and ensure that these sites are safe in the meantime. We further urge the administration to develop a plan to phase out the use of commercial hotels as shelter for families with children. This will require developing a plan to expand the City's Tier II shelter system.

b. Improve Conditions in the City's Shelter System

The City must also continue its efforts to repair and modernize existing Tier II shelters. Disrepair and other hazardous conditions have been endemic in the DHS shelter system.[13] Homeless families should not be required to reside in unhealthy, moldy, pest-infested, or otherwise unsafe conditions. These conditions obviously impact the mental health of the shelter residents. CCC urges the Administration and the City Council to continue efforts to ensure that every shelter in New York City is safe for habitation.

c. When Safe, Place Families in their Communities

A crucial component to improving conditions for families in shelter involves placing them in their own communities whenever it is safe to do so. Placing a family in a shelter far from their community makes it harder for their children continue attending the same school, lengthens commute times to work, disrupts their ability to continue receiving services at community based organizations, prevents them from receiving health care services at the same doctor, and would

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[11] An Investigation into the Provision of Child Care Services in New York City Homeless Shelters, p. 20 (available at http://comptroller.nyc.gov/wp-content/uploads/documents/Homeless-Child-Care-Report_October.pdf).

[12] Id. at p. 21.

[13] Audit Report on the Controls of the Department of Homeless Services over the Shelter Placement and the Provision of Services to Families with Children, p. 9 (available at http://comptroller.nyc.gov/wp-content/uploads/documents/MG14_088A.pdf).

disconnect them from child welfare services provided by community based organizations in their former neighborhood.[14]

At present, DHS makes efforts to place families in the borough of their youngest child's school. However, as a result of crowding in the shelters, the number of families able to be placed in the same borough as their youngest child's school has dropped from 88.3% to 52.9%.[15]

We believe that at PATH intake, DHS should conduct a broader assessment of a family's needs band place the family accordingly. For example, families receiving ACS preventive services should be placed in the same community where they are receiving those services. Similarly, if a child or parent has a mental illness and is receiving community-based services, it would be valuable to ensure continuity of care.

d. All DHS, HRA Domestic Violence and Shelter Provider Staff Must Be Trained in Providing Trauma-Informed Care Throughout the Shelter System

It is critical that every single person who comes into contact with homeless families, from the security guard to the janitor to the social worker, be trained in trauma and trauma-informed care. Homeless children and their families have experienced trauma by virtue of being homeless, and many have experienced many other traumatic life experiences.

Children experiencing trauma suffer from long-term negative outcomes in both their mental and behavioral health, and adults experiencing trauma are more likely to struggle with substance or mental health issues.[16] By adopting a trauma-informed approach to each stage of the shelter system, the system will have the opportunity to mitigate these negative outcomes and provide support for families in crisis.

2. Ensure that Families in Need of Mental Health Services Are Expeditiously Provided with Necessary Services

In addition to improving living conditions for families in shelter, it is critical that we ensure the homeless shelter system is able to expeditiously provide, either on site or through referral, mental health services to all the families that require them.

CCC calls upon DHS to develop a mechanism to provide mental health services, either on-site or through a referral to off-site services, to each individual residing in shelter, including children. In the short term, this must include a plan for families in cluster sites and hotels.

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[14] Not Reaching the Door: Homeless Students Face Many Hurdles on the Way to School, p. 19 ("Parents said that not having adequate and convenient child care made it difficult to meet work and school demands; there was insufficient time to drop off their children and then get to work on time given the longer distances they often had to travel from their shelter than when they had been permanently housed. ") (available at http://www.ibo.nyc.ny.us/iboreports/not-reaching-the-door-homeless-students-face-many-hurdles-on-the-way-to-school.pdf).

[15] Not Reaching the Door: Homeless Students Face Many Hurdles on the Way to School, p. 22 (available at http://www.ibo.nyc.ny.us/iboreports/not-reaching-the-door-homeless-students-face-many-hurdles-on-the-way-to-school.pdf).

[16] The Forgotten Face of Homelessness, p. 19 (available at http://winnyc.org/wp-content/uploads/2016/10/forgotten_face_whitepaper_FINAL.pdf).

3. **Better Address the Needs of Vulnerable Families that May Have Had Contact with the Child Welfare System (the Administration for Children's Services)**

There are a number of reform efforts that could be taken to better meet the needs, including mental health, for families and children in shelter who may have had contact with ACS or are at risk of contact with ACS.

These recommendations include:

- Expanding the use of homevisiting programs, such as Nurse-Family Partnership and Healthy Families New York for families in shelter.
- Expanding the City Council's initiative that provides trauma-informed services and primary prevention services to families in shelter who have children under 5.
- Modifying the shelter system's "no visitor" policy, which results in socially isolating parents from their support systems (such as family, friends and babysitters.)
- Ensuring families with open ACS cases are able to maintain continuity of care with their service providers.

4. **Increase the Number of Licensed Master Social Workers in NYC Schools and Baseline Funding for the 33 Currently Funded**

In the budget for Fiscal Year 2017, the City allocated $10.3 million in order to provide educational services for children in shelter, including funding for 33 social workers in New York City's schools to provide additional support to homeless students. CCC calls on the Mayor and City Council to increase the number of these social workers to 100 and to baseline this necessary funding so that this program may be available to homeless students in the future.

5. **Pass Int. 932-2015, a Local Law requiring DHS to annually report on mental health services provided to individuals and families in the shelter system**

Local Law 932-2015 would require DHS to report on a number of data elements that would shed light on both the mental health services being provided, as well as the mental health needs, of those in the shelter system. CCC supports Local Law 932-2015 and urges the City Council to pass it.

Specifically, this bill would require annual reports that would include:

- The number of shelters with on-site mental health services and a description of these services.
- The number of shelters that provide mental health services by referrals, including the average travel time to the referral.
- A description of mental health services at each intake facility (including PATH).
- A list of the top 10 mental health issues for adults and children living in shelter.

To strengthen this bill, CCC suggests that the City Council expand the requirements to include the children and families in the Domestic Violence shelter system.

CCC looks forward to continuing to work with the administration and the City Council to better meet the mental health needs of the children and families in the shelter system.

Thank you for the opportunity to testify.

Testimony of
Coalition for the Homeless
And
The Legal Aid Society

On

Oversight – Part 2: Mental Health Services in the DHS Shelter System

Presented before

The New York City Council
Committee on General Welfare
Committee on Health

Giselle Routhier
Policy Director
Coalition for the Homeless

Joshua Goldfein
Staff Attorney
The Legal Aid Society

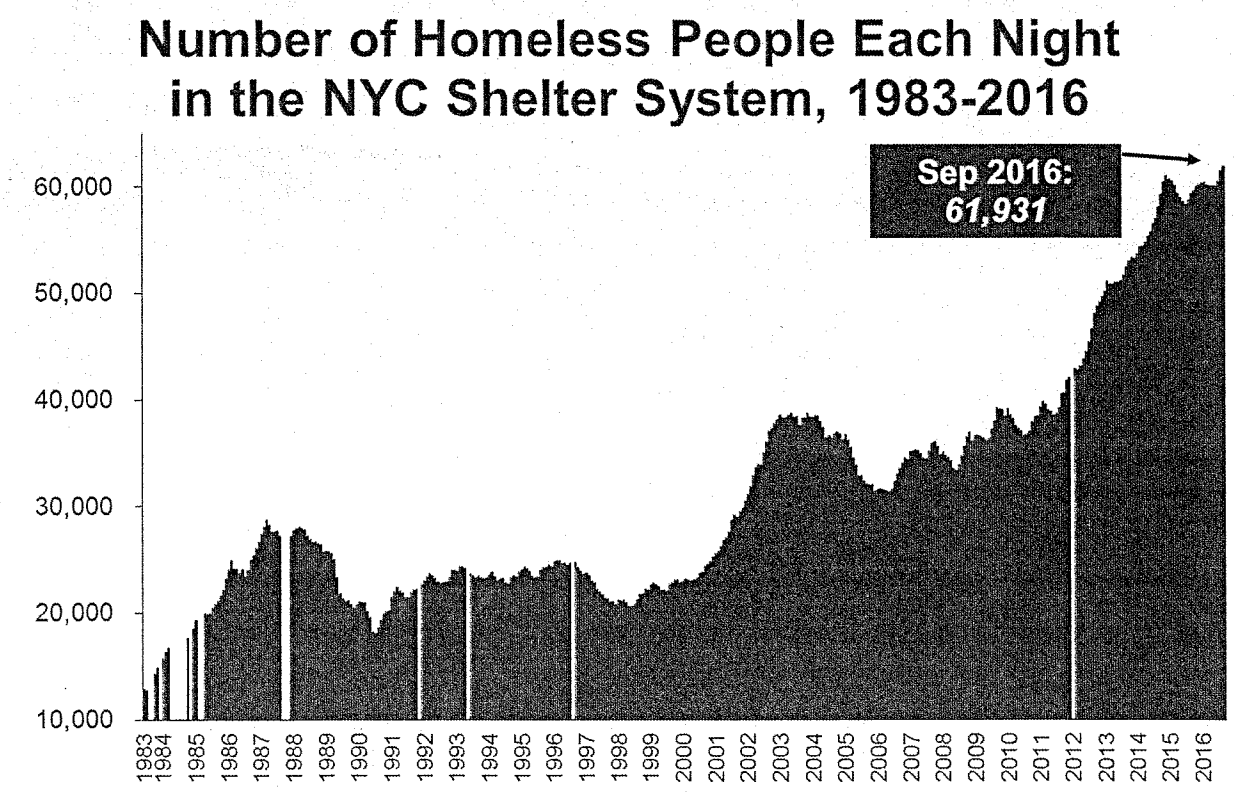
November 21, 2016

Coalition for the Homeless and The Legal Aid Society welcome this opportunity to testify before the Committees on General Welfare and Health regarding mental health services in the DHS shelter system.

Background: Homelessness in NYC

New York City remains in the midst of the worst homelessness crisis since the Great Depression. In September 2016, an all-time record 61,931 men, women, and children slept in shelters each night on average. Over the past decade, homelessness among single adults has nearly doubled and family homelessness has increased by more than 80 percent.

Homeless individuals experience increased rates of severe mental illness compared with rates within the general population.[1,2] A quarter of all homeless individuals suffer from severe mental illness, and rates are significantly higher for those that are chronically homeless. Among families, mothers experience extraordinarily high rates of depression and posttraumatic stress disorder.[3] Homeless children also experience higher rates of emotional and behavioral problems than low-income children living in permanent housing.[4] There are more individuals in homeless shelters with severe mental health needs than available placements in shelters augmented with onsite mental health services designed to assist them. The City and State must work together to correct this disparity.



Source: NYC Department of Homeless Services and Human Resources Administration and NYCStat, shelter census reports

The Legal Aid Society, on behalf of Coalition for the Homeless and the Center For Independence of the Disabled, New York (CIDNY), brought Butler v. City, a class action lawsuit on behalf of all disabled shelter residents, and they are in negotiations with the City to address these issues.

Mental Health Services in DHS Shelter System and the Critical Need for Supportive Housing

Most shelters are not equipped to handle the needs of individuals with severe mental illness. Without proper training and support shelter staff are often unaware of how to identify or respond to clients with psychiatric disabilities. Increasing security at mental health sites has been a common response to clients whose behavior may reflect symptoms and conflicts that arise between residents. This can create distance between residents and staff and may reduce the willingness of clients to stay at the shelter they require in order to remain stable and improve their well-being. Improved staff development and instruction could help staff use interventions to de-escalate or otherwise avoid conflict and engage clients in necessary services.

Accessing emergency psychiatric help, even for those that willingly request it, has also become more difficult recently as a result of the gatekeeping inherent in Medicaid redesign. Notable changes include more limited access to inpatient psychiatric care, shorter hospitalizations, and reduced access to preventative services such as well-trained intensive case management and ACT (Assertive Community Treatment) teams. For instance, we have seen clients wait for ACT team services as long as a year or more even for severely disabled individuals living in shelters or on the streets.

In addition, social and psychiatric respite services are not available to individuals who are not stably and permanently housed, leaving no avenue for emergency intervention for psychiatrically disabled homeless men and women. Expanding the availability of these services making them immediately available for those in crisis would better help people live in the least restrictive setting possible and ensure that they do not end up in temporary housing without access to the care they need.

Moreover, individuals are routinely discharged from hospitals to shelters without proper vetting for the appropriateness of the placement, placing them at risk for preventable re-hospitalization. Clients who have just been discharged from a hospital typically wait well into the night to find out if a bed will be available at their assigned shelter. Ultimately many are transferred to an entirely new facility – resulting in additional emotional trauma and disruption in the continuity of services. Premature discharges can lead to clients being denied shelter and turned away to the streets. As we have seen in some well-publicized incidents, improper or premature discharges can jeopardize the safety of the client and others within the shelter system, including other shelter residents and staff.

Improving critical access to community-based and inpatient mental health care will require the assistance of the State, which licenses both psychiatric facilities and Medicaid managed care plans, and is the architect of Medicaid redesign. The recent carve-in of behavioral health services into Medicaid managed care and the rollout of new Health and Recovery Plans (HARPs) provide

opportunities for better coordination of care but also create risk that vulnerable individuals will lose access to crucial services.

Of particular value for the long term is the proven solution of supportive housing, which provides stable, permanent housing with onsite support services for individuals and families in need of extra support such as those with serious mental illness and other disabilities. Supportive housing is the solution to the problem of chronic homelessness among those with mental illness. Those in supportive housing will be more likely to effectively navigate the changing Medicaid landscape.

Through the steadfast advocacy of hundreds of our partners in the Campaign 4 NY/NY Housing, including scores of elected officials and hundreds of faith leaders, we succeeded in winning promises from both Mayor de Blasio and Governor Cuomo to create a total of 35,000 units of supportive housing in the next fifteen years. The City is on track to open the first 500 units of supportive housing under the Mayor's 15,000-unit commitment this year.

While the State has made some conditional awards for some of it units as well, there is a stalemate in Albany with respect to the release of the full $2 billion Governor Cuomo promised to fund the first 6,000 units of his commitment to build 20,000 units of supportive housing statewide. We continue to urge the Governor and legislative leaders to make good on this crucial promise.

We thank the Council for the opportunity to testify. We look forward to working together on our mutual goal of ending homelessness in New York City.

About Coalition for the Homeless and The Legal Aid Society

Coalition for the Homeless: Coalition for the Homeless, founded in 1981, is a not-for-profit advocacy and direct services organization that assists more than 3,500 homeless New Yorkers each day. The Coalition advocates for proven, cost-effective solutions to the crisis of modern homelessness, which is now in its fourth decade. The Coalition also protects the rights of homeless people through litigation involving the right to emergency shelter, the right to vote, and life-saving housing and services for homeless people living with mental illness and HIV/AIDS.

The Coalition operates 11 direct-services programs that offer vital services to homeless, at-risk, and low-income New Yorkers. These programs also demonstrate effective, long-term solutions and include: Supportive housing for families and individuals living with AIDS; job-training for homeless and formerly-homeless women; and permanent housing for formerly-homeless families and individuals. Our summer sleep-away camp and after-school program help hundreds of homeless children each year. The Coalition's mobile soup kitchen distributes over 900 nutritious hot meals each night to homeless and hungry New Yorkers on the streets of Manhattan and the Bronx. Finally, our Crisis Intervention Department assists more than 1,000 homeless and at-risk households each month with eviction prevention, individual advocacy, referrals for shelter and emergency food programs, and assistance with public benefits as well as basic necessities such as diapers, formula, work uniforms, and money for medications and groceries.

The Coalition was founded in concert with landmark right to shelter litigation filed on behalf of homeless men and women (*Callahan v. Carey* and *Eldredge v. Koch*) and remains a plaintiff in these now consolidated cases. In 1981 the City and State entered into a consent decree in *Callahan* through which they agreed: "The City defendants shall provide shelter and board to each homeless man who applies for it provided that (a) the man meets the need standard to qualify for the home relief program established in New York State; or (b) the man by reason of physical, mental or social dysfunction is in need of temporary shelter." The *Eldredge* case extended this legal requirement to homeless single women. The *Callahan* consent decree and the *Eldredge* case also guarantee basic standards for shelters for homeless men and women. Pursuant to the decree, the Coalition serves as court-appointed monitor of municipal shelters for homeless adults, and the City has also authorized the Coalition to monitor other facilities serving homeless families.

The Legal Aid Society: The Legal Aid Society, the nation's oldest and largest not-for-profit legal services organization, is more than a law firm for clients who cannot afford to pay for counsel. It is an indispensable component of the legal, social, and economic fabric of New York City – passionately advocating for low-income individuals and families across a variety of civil, criminal and juvenile rights matters, while also fighting for legal reform.

The Legal Aid Society has performed this role in City, State and federal courts since 1876. It does so by capitalizing on the diverse expertise, experience, and capabilities of more than 1,100 lawyers, working with some 800 social workers, investigators, paralegals and support and administrative staff. Through a network of borough, neighborhood, and courthouse offices in 26

locations in New York City, the Society provides comprehensive legal services in all five boroughs of New York City for clients who cannot afford to pay for private counsel.

The Society's legal program operates three major practices — Civil, Criminal and Juvenile Rights — and receives volunteer help from law firms, corporate law departments and expert consultants that is coordinated by the Society's Pro Bono program. With its annual caseload of more than 300,000 legal matters, The Legal Aid Society takes on more cases for more clients than any other legal services organization in the United States. And it brings a depth and breadth of perspective that is unmatched in the legal profession.

The Legal Aid Society's unique value is an ability to go beyond any one case to create more equitable outcomes for individuals and broader, more powerful systemic change for society as a whole. In addition to the annual caseload of 300,000 individual cases and legal matters, the Society's law reform representation for clients benefits more than 1.7 million low-income families and individuals in New York City and the landmark rulings in many of these cases have a State-wide and national impact.

The Legal Aid Society is counsel to the Coalition for the Homeless and for homeless women and men in the Callahan and Eldredge cases. The Legal Aid Society is also counsel in the McCain/Boston litigation in which a final judgment requires the provision of lawful shelter to homeless families.

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[1] SAMHSA. (2011). Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States

[2] National Institute of Mental Health (2014). Serious Mental Illness (SMI) Among U.S. Adults. Available online: https://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml

[3] SAMHSA. (2011). Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States

[4] Routhier, G. (2012). Voiceless Victims: The Impact of Record Homelessness on Children. Available online: http://www.coalitionforthehomeless.org/wp-content/uploads/2014/06/BriefingPaper-VoicelessVictims9-25-2012.pdf

SAFETY NET ACTIVISTS

Supported by the Safety Net Project at the Urban Justice Center

WENDY O'SHIELDS TESTIMONY
THE CITY OF NEW YORK'S
Committee on General Welfare jointly with the
Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

Oversight Part 2
Mental Health Services in the DHS shelter System
Int. No. 932 - in relation to requiring information on mental health services in shelters

November 21, 2016

THE MENTALLY HEALTHY DHS RESIDENTS ARE A DEPARTMENT OF HOMELESS SERVICES INVISIBLE POPULATION

My name is Wendy O'Shields and I'm testifying as a Safety Net Activist.

3 years, 5 years, 12 years or longer are some of the time periods served by Department of Homeless Services shelter residents who are mentally healthy. Many of the over-40 mentally healthy residents are residing in the DHS shelters because of lack of work or because their wages are not sufficient to pay market rent.

The mentally healthy are overcrowded and mixed in with the mentally ill and mentally ill violent residents. The lack of proper treatment and services for those with mental illness creates an unstable environment that affects everyone; both those suffering from mental illness and other shelter residents. This environment is inhumane and criminal!

This environment severely threatens the safety and lives of the mentally healthy residents. Many mentally healthy residents develop stress related physical illnesses as a result of their daily exposure to the unhealthy environment.

There are many mentally healthy residents in the DHS Shelter system. They have historically been hidden from the general public or been ground down over time into MICA as a result of the traumatic environment.

DHS best practice of mixing all individuals with no services or treatment for the mentally ill has been in place for decades. They call it "General Population." Is the purpose of this DHS policy to comprise the physical and mental health of an otherwise fully functioning New Yorker? Does DHS believe that leaving mental illness untreated is acceptable? Does DHS prefer to take their chances with the beatings doled out by the Emotional Disturbed Persons? Are the occasional murders of DHS residents statistically acceptable to the City of New York?

Mentally healthy, educated, with a work history, and current or former taxpayers should not be allowed to deteriorate in every way during a long-term tenancy with DHS as their Landlord. Instead, the mentally healthy should be fast track to independent permanent housing with a Housing Choice Vouchers, HPD, NYCHA, and other permanent housing which they are eligible. Mentally ill residents can be prioritized for these same programs or supportive housing as appropriate.

Please enforce the DHS Shelter Homeless priority codes for HPD Affordable Housing, NYCHA, and other New York City permanent housing agencies.

Please consider my suggestions to correct the crimes in progress against all DHS residents.

Thank you for hearing my concerns.

ENDNOTES

HUD DEFINITION OF "CHRONIC #HOMELESS"
The cumulative total of the length of #homelessness spent living in a place not meant for human habitation, a safe haven, or in an "EMERGENCY SHELTER" must be at least 12 months. https://www.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf

MICA Mentally Ill Chemically Addicted

EDP Emotionally Disturbed Person

Oversight Part 2 - Mental Health Services in the DHS shelter System
Int. No. 932 - in relation to requiring information on mental health services in shelters

Monday November 21,2016
Monday, November 21, 2016 at 10:00 A.M. in the 14th Floor Committee Room, 250 Broadway, New York, NY

Council members: Levin, Chin, Cumbo, Eugene, Koo, Rose, Cohen, Dickens and Johnson

Good Morning Councilmembers,

Representatives: Lucina Clarke, Executive Director, My Time Inc
Brett Scudder
Christina Sparrock
Esther Wilson

Thank you for giving myself and members of My Time Inc this opportunity to testify before you on the experience of one of our clients from My Time Inc who is currently in a Mental Health Shelter. Firstly, My Time Inc is a not for profit organization that provides support, education, advocacy and emotional wellness workshops for parents of a child with Autism and any Developmental Disabilities. We have been providing services to the community for nearly nine(9) years. We are here on behalf of our parents speaking out on the need to provide effect mental health services to individuals or families in the shelters. We are here hopefully to provide a solution which may aid in your decision making of providing effective and efficient mental health services to individuals.

The case:

Hispanic woman, age 43 is displaced from her home due to a domestic violence situation. Everything seemed to go wrong. First, the initial process of going into the shelter, asking the security guard a question and not being treated as a human being. Secondly, the intake process and finally being placed in a mental health shelter.

While placed in this center, the horrifying stories she tells of living there, getting minimum services, insulted and treated unfairly. When she ask questions or makes inquiries about programs, she is spoken to in such a belittling manner. This individual still lives in a shelter. S0he is in a different one now because she felt her life was being threatened. She complies with the rules but to no avail services denied. She finally gets a voucher to find an apartment. She felt that this will change her life, unfortunately no. There are many challenges she faces as she looks for the apartment. There are road blocks, bureaucracy and minimum supports for the individuals in some of these shelters.

The team is proposing three solutions shown below

One immediate solution is for homeless shelters to model a Crisis Respite Center

Crisis Services/Mental Health: Crisis Respite Centers

What:

-Crisis Respite Center provides an alternative to hospitalization

For:

-for people experiencing emotional crises.

Setting:

- They are warm, safe and supportive home-like places to rest and recover

Period:

Individuals can stay for up to 1- week and provides an open-door setting where people can continue their daily activities.

Staff:

Trained peers and non-peers work with individuals to help them successfully overcome emotional crises or develop a plan to move forward. Peer specialists are people with lived experience who focus on the principle of recovery

Solution Two: Affordable housing

One of the biggest issues some people with mental illness face is the availability of housing. For many people, having a mental health condition has no impact on their housing. Most people can and do live independently in apartments or in their own homes. For others, the cascading effects of mental illness might leave them in a precarious housing situation, or even cause them to lose their homes. Having a safe and secure place to live is an important part of recovery, along

with access to services that enable those with mental health conditions to live as independently as possible.

Having a mental health condition can make finding and keeping a home challenging. If you are poor, renting an apartment may be beyond your means. Affordable housing may be available, but located in unsafe or hard to reach places. You may be placed in a group home or apartment where there will be rules to follow and you will be living at close quarters with people you don't know. Your illness can interfere with your ability to comply with rules, keep your home up, get along with others or meet lease requirements. Nonetheless, there is cause for hope as you travel along your road to recovery. Although it may take some time to find yourself a home, the different types of housing described here can provide you with the services, support and affordability that you need at this time in your life.

Solution Three: Education: Let's talk about it.

There should be workshops/ forums giving people the tools to know how to ask for help when they may feel stressed or overwhelm. Let's have conversations where people can feel safe and not threatened because of their mental illness.

Some mental health professionals are not as compassionate or empathetic to the needs of these individuals in a shelter. There should be more training in dealing with the individuals with a mental disability. Proper services of support and resources must be made available.

Sometimes the language has to change. There is such a taboo on the word mental illness lets focus on the emotional wellness. Let's really start checking in on our emotions and others.

Thank you for giving us the opportunity to speak.

Good Morning and thank you to Chairman Levin, Chairman Johnson and the members of the Health and General Welfare Committees for the opportunity to testify today.

My name is Lynnette Verges. I am the Director of Social Work at Care for the Homeless. Our agency provides primary care and behavioral health services to homeless individuals and families in congregate settings such as soup kitchens, drop in centers and shelters. It is widely known that the prevalence of mental health issues is much higher among people experiencing homelessness than in the general population. Yet the majority of NYC shelters don't have co-located treatment services available.

Mental health treatment in the community is often unavailable due to limited access and long waiting periods. Homeless clients/families are often in crisis when they first enter the shelter system and they need treatment and support to help them attain stability. While this is a need, it is often not the priority in the midst of crisis as they work to ensure their basic needs are met. When individuals and families have treatment onsite which is accessible and available this translates into better health outcomes; clients are able to seek and maintain employment, transition successfully into permanent housing and do well in their communities. Children and adolescents are able to perform better in school and transition out of homelessness successfully. Homeless clients face many systemic barriers in accessing entitlements, health insurance and housing but if treatment is available at all New York City shelters it provides an essential opportunity for clients to receive the treatment needed to transition from crisis to stability.

Please consider doing whatever is necessary to provide appropriate critically needed and co-located mental health treatment services at New York City shelters. It is the right thing to do. It will provide far better outcomes for the families, children and adults in the shelter system and far better outcomes for our communities. It is a cost effective approach ensuring homeless people have the opportunity to achieve their highest potential.

Thank you.

Testimony by Bradley Rapanut, Program Director Pyramid Safe Haven, BronxWorks

Re: Int. No. 0932-2015 – In relation to: Requiring information on mental health services in shelters.

Before the New York City Council, Committee on Health and Committee on General Welfare

November 21, 2016

Chairman Cohen and Chairman Levin, Council Members, and staff, good afternoon and thank you for the opportunity to speak about this proposed bill and the subject of addressing the mental health needs of the homeless population in New York City. My name is Bradley Rapanut and I am a Program Director at BronxWorks. I currently oversee the Pyramid Safe Haven program, a transitional shelter with 75 beds for chronically street homeless adult males. BronxWorks is a large multi-service agency that has worked in the Bronx since 1972 and runs a number of programs including after-school, community and senior centers, ESL classes, and food stamps access. BronxWorks currently provides a wide range of homeless services including prevention, family shelters, homeless outreach, the only drop-in center for homeless adults in the Bronx, Safe Havens and permanent supportive housing. We are proud of our collaborative relationship with the Department of Homeless Services (DHS) that has allowed us to provide innovative solutions which have helped reduce street homelessness in the Bronx by 88% between 2005 and 2015.[1] Since we provide a continuum of care for homeless individuals and families – beginning from street outreach, through transitional housing, and successful placement into permanent housing – we have an in-depth understanding of the wraparound services that are needed in order to move someone from homelessness to permanent housing. Mental health care is an integral part of the necessary services to address the wide range of mental health challenges our clients face.

The mental health needs of the adult homeless population are especially complicated and often contribute to individuals continued homelessness. In our adult homeless facilities, we have found that approximately 30% to 50% of our clients self-report experiencing a mental illness, of which approximately one-third have a diagnosable serious mental illness – such as schizophrenia or bipolar disorder. Almost every week, at least one client from our programs goes to the hospital, because they are assessed as being at-risk of harming themselves or others. Additionally, between 30% to 70% report they are currently struggling with, or have a history of, drug or alcohol use, and 30% to 50% report a co-occurring disorder of both mental illness and substance use. Further, we have identified that about 10% of the heads of household in our family shelters experience a serious mental illness. In the aftercare program for our family shelters, 68% of participants report experiencing complex trauma. For these reasons we support this bill because it will serve as a valuable starting point from which to drill down on the core issue at hand, which is the inability of the shelter system and the hospitals to

[1] New York City Department of Homeless Services. "HOPE NYC Street Survey 2015 Results." http://www.nychomeless.com/downloads/pdf/Latest_News/HOPE_2015_Presentation-07242015.pdf.

effectively collaborate in order to best meet the mental health and housing needs of homeless people.

At this time, DHS and hospital systems are unable to effectively coordinate and transition care from the hospital to shelter and vice versa. Homeless individuals are often admitted to a psychiatric emergency department and after being prescribed a medication regimen they are discharged after a few days. In the case of a person with a co-occurring disorder, often they are not seen by the psychiatric unit, but rather treated directly for intoxication and then discharged from the emergency department. In either scenario, upon discharge individuals may end up returning to the street after being referred to a homeless intake center; or if they do make it to a shelter, they are at-risk of another mental health emergency because of the lack of information sharing and coordination regarding the client's diagnosis, medication, and treatment. Homeless individuals with mental illness often cycle through this same pattern repeatedly. One example out of many, is a 65-year-old Hispanic male, who reports being homeless since the age of 16, and has a documented shelter history ranging back to 1997. He has been diagnosed with schizophrenia and polysubstance use disorder, as well as diabetes and cirrhosis of the liver. The earliest psychiatric hospitalization that he remembers was in his early 20's, during which time he reports he started to hear voices. He has been in and out of shelters, safe havens, drop-in centers, and treatment programs, without reporting much success. While currently in one of our Safe Haven programs, we have seen him cycling in and out of hospitals while his ability to manage his medical and mental health conditions has not improved. Cases like this serve as prime examples of how the accessibility of information sharing throughout shelters and hospital systems could help to facilitate coordinated care, and improve quality of life for those who are most vulnerable.

Further, there is a significant population of hospital homeless individuals, who completely circumvent the shelter system due to this breakdown in communication. During this year's HOPE Count, which counts all street homeless individuals in the city during a night in February, 47 individuals were counted on the street in the Bronx. However, the Bronx Health & Housing Consortium conducts a parallel count of all homeless individuals staying the night in hospital waiting rooms, hallways and emergency departments. The Consortium counted 87 homeless individuals across nine Bronx hospital locations, which is nearly double the HOPE Count total. The majority of these individuals reported more than 10 emergency department visits in the past year. As they are not currently included in the HOPE Count, the shelter system is missing the opportunity to provide services for these individuals. Unless an individual is registered in the DHS CARES system, and has a documented history of homelessness, they are unable to receive priority for permanent housing placement since they do not meet the DHS or HUD definitions of chronically homeless. For this reason, it is also vital that the hospitals be required to report on the number of referrals they make to the shelter system as some individuals referred to shelter do not successfully make it and return to the street instead, and thus fall through the cracks in the system.

At present, the shelter system is often falling short of providing appropriate wraparound services for these individuals to improve their mental health outcomes. The proposed bill will provide an opportunity to develop further insight into how these issues can be addressed and would open up communication to help coordinate care for these individuals between social services and mental health providers. Since March 2016, the BronxWorks Homeless Outreach Team (HOT)

has engaged over 500 homeless individuals in Bronx hospital emergency departments (ED), and of those, they transported over 120 to either shelter, or a drop-in center.

On average, BronxWorks receives over 28 calls per month from hospital staff regarding the discharge of homeless patients. This clearly demonstrates the need for an open line of communication between shelters and hospitals to ensure smooth discharges, and lower the number of readmissions due to poorly coordinated care. One of the easiest ways to begin this collaboration is to grant hospitals access to the DHS CARES database (the database of record for the Department of Homeless Services). This database provides information about an individual's history of homelessness, medical and psychiatric conditions, and information about their last shelter stay. It is vital that hospitals be given access to this system so that mental health providers and shelters can effectively share information to best serve homeless people with mental health needs. If hospitals could send a discharge summary through CARES when referring an individual to the shelter system, it would head-off many of the mental health emergencies that force homeless people to leave shelter and re-enter the hospital.

In addition, unless an individual is registered in the DHS CARES system they may not have access to some permanent housing opportunities because their length of homelessness is not documented. This can be particularly problematic if the person has been circumventing the traditional shelter system by using hospitals or other non-shelter facilities as a de facto place of residence. Granting mental health providers, including hospitals, access to the CARES system would allow for hospitals, social service and shelter providers to work together and build a comprehensive picture of the client's needs, including length of homelessness, so that individuals have more housing opportunities.

Alongside access to CARES, both hospitals and shelter providers should be able to directly refer clients to mental health shelters instead of forcing high-needs clients to go through the normal intake and assessment centers. We have found that this can be extremely challenging for individuals with mental health needs, especially if they have a serious mental illness, and often may be an experience that re-traumatizes the person. This current process is ineffectively using the expertise of mental health professionals at hospitals and shelter providers who should be able to directly refer clients to a program shelter, when appropriate.

Another issue that is presented by the current state of mental health services in the shelter system is that most psychiatric services provided in shelters are focused on documentation and diagnosing, for the purpose of submitting a housing packet, versus providing ongoing psychiatric treatment. Often mental health treatment is left up to outpatient referrals, which we have seen varied success in client follow-through. This balance needs to be more closely considered by DHS in order to better serve the mental health needs of our clients.

One additional area of concern between the shelter and hospital systems, while not as common, is the need for Assisted Outpatient Treatment (AOT) or an Assertive Community Treatment (ACT) team. These services, which are outlined in Kendra's Law, are aimed at supporting individuals with serious mental illness who are assessed by licensed professionals to present a danger to themselves or others in the community, if not supervised, and have demonstrated an unwillingness to voluntarily engage in treatment or services. The use of AOT is to prevent the relapse or deterioration in functioning, which would likely result in serious harm to themselves or

others. These services are particularly challenging to coordinate for the homeless population, as they require that individuals have a fixed address outside of the hospital. In our experience, we often have hospitals contact us asking to use the address of our drop-in center, in order for AOT to be provided. A more coherent plan needs to be adopted for servicing the mental health and housing needs of this exceptionally vulnerable population.

We are at a critical juncture in this discussion and the climate is right for the mental health community and homeless services to come together to address the interlinked mental health and housing needs of the homeless. Greater information sharing through hospital access to CARES, changing the referral process for program and mental health shelters, more closely examining AOT/ACT regulations as they pertain to the homeless population, and the reporting requirements listed in this bill are concrete solutions that can be implemented at this time to address the larger issues surrounding the social determinants of health.

Once again, thank you for your time and attention to this testimony. BronxWorks looks forward to continuing our collaboration with DHS to find valuable solutions toward meeting the needs of New York City's homeless population. We welcome the opportunity to discuss these issues further with you and DHS.

Respectfully Submitted,

Bradley Rapanut, LMSW

Program Director, Pyramid Safe Haven
BronxWorks

urban pathways
for homeless new yorkers, the way home.

TESTIMONY
New York City Council Oversight Hearing
Mental Health Services in the DHS Shelter System
Presented by Nicole Bramstedt

November 21, 2016

Good Morning. My name is Nicole Bramstedt. I am the Director of Policy at Urban Pathways. Thank you to the New York City (City) Council Committee on General Welfare and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services for holding this hearing on mental health services in the DHS shelter system and the opportunity to testify.

Urban Pathways will testify on the mental health issues and needs of homeless adults outside of the City shelter system, namely those in drop-in centers and safe havens. We will provide recommendations for ensuring the City better assess and address these issues. These include enhanced reporting and assessment of mental health data for this population and increased City investment in its drop-in center and safe haven contracts to better address these needs.

About Urban Pathways

Since 1975, Urban Pathways has worked to engage the City's most vulnerable – chronically homeless individuals and those exiting state psychiatric hospitals – and provide them with "a way home". Our continuum of programs, in four of the five boroughs, include five non DHS contract street outreach programs, the Olivieri Drop-in Center, the Hegeman and Travelers Safe Havens, eight supportive housing residences, and nearly two hundred scattered site supportive housing units.

Background

In Fiscal Year (FY) 2016, Urban Pathways served over 500 homeless adults outside the shelter system, at Olivieri Drop-In Center (342 individuals) and Travelers Safe Haven (94 individuals) in midtown Manhattan and Hegeman Safe Haven (108 individuals) in Brooklyn. The first part of my testimony will address the mental health issues and needs we encounter in serving individuals at the Drop-In Center and Safe Havens and the need for improvements and investment to better address such.

Unsheltered Homeless Adults Have High Rates of Mental Illness.

Mental illness disproportionately impacts homeless adults living on the streets or outside the shelter system. The U.S. Interagency Council on Homelessness estimates over one-half of chronically homeless adults have a mental illness.[1] According to Coalition for the Homeless, the large majority of street homeless New Yorkers have a mental illness or severe health issue.[2] The Coalition estimates at least one-third of homeless adult New Yorkers have a severe mental illness, substance abuse issue or both.[3]

[1] The U.S. Interagency Council on Homelessness. Background Paper – Chronic Homelessness. https://www.usich.gov/resources/uploads/asset_library/BkgrdPap_ChronicHomelessness.pdf. June 2010.
[2] Coalition for the Homeless. Basic Facts about Homelessness: NYC. http://www.coalitionforthehomeless.org/basic-facts-about-homelessness-new-york-city/.
[3] Coalition for the Homeless. A Growing Crisis for Single Adults. http://www.coalitionforthehomeless.org/wp-content/uploads/2016/08/Briefing-Paper-Single-Adult-Homelessness_FINAL.pdf. August 2016.

This mirrors what we see in the unsheltered homeless adults we serve at Olivieri Drop-In Center and the Safe Havens. In September 2016, 37 of the 92 Drop-In Center clients (40 percent) were diagnosed with a mental illness by a psychiatric assessment. In October 2016, twelve of 25 new Drop-In Center clients were diagnosed with a mental illness or mental illness chemical addiction (MICA) by intake assessment, nurse assessment or psychosocial assessment. At Hegeman Safe Haven in October 2016, three of four new clients were diagnosed with a mental illness or MICA by a psychiatric assessment.

These data are a snapshot of the information that Urban Pathways regularly collects on the mental health issues of our unsheltered clients. The Drop-In Center monthly reports on the number of clients on medications – psychotropic and non-psychotropic. The Drop-In Center and the Safe Havens monthly report on the number of psychiatric referrals – internal Project Renewal and outside referrals. With respect to psychiatric referrals, both sites tabulate Project Renewal appointments kept and no shows as well as whether referrals are first time evaluations, follow-ups or updates. In addition, the Drop-In Center sends a monthly report to DHS, which reports on the number of clients with a mental illness and a substance abuse issue. In addition, each site monthly reports on the number of new clients at each site with a mental illness, a substance abuse issue and MICA for a Robin Hood Foundation grant.

Our Drop-In Center and Safe Havens Constantly Work to Assess and Address Clients' Mental Health.

Olivieri Drop-In Center and Travelers and Hegeman Safe Havens assess clients for mental illness as well as facilitate mental illness diagnosis and treatment of clients.

Mental Health Assessment
At the Drop-In Center, mental health assessment occurs as follows for individuals who enroll in drop-in services during daytime hours. An individual receives an intake, consisting of questions touching on mental health. Also, the fulltime nurse does an assessment, and the case manager, once assigned, conducts a psychosocial assessment of the client, both touching on mental health.

Individuals who do not enroll in drop-in services, such as those who arrive at night, instead receive a preliminary assessment. This inquires about the following, to evaluate if the client is mentally stable to stay the night: client appears high or intoxicated; client needs immediate medical attention; client has medication; and client is a danger to self or others. Also, clients who arrive at night who feel suicidal or decompensate may be escorted to the hospital by the NYPD for further assessment.

Mental health assessment of Safe Havens clients is as follows. Clients come in with a brief psychosocial from the outreach provider who brought the client in from the street. A Safe Haven case manager conducts a psychosocial assessment within 30 days of the client's admission. A part-time nurse also conducts a health assessment, which touches on mental health.

Then, a client receives a psychiatric assessment, which is required for the HRA 2010e City Supportive Housing Application and updated at least every six months. Drop-In Center and Travelers Safe Haven clients see a Project Renewal psychiatrist onsite at Olivieri or their own psychiatrist. Olivieri has a consultant line in its DHS contract for psychiatry for Olivieri and Travelers clients. This funds three part-time Project Renewal psychiatrists who are onsite on Tuesday (nine hours), Wednesday (eight hours) and Thursday (three hours). There is a waiting list for the Project Renewal psychiatrist.

Hegeman Safe Haven clients see a psychiatrist from the Project Renewal Med Van or their own psychiatrist. Hegeman has a consultant line in its DHS contract. This funds a part-time nurse one day a week for three hours and a part-time Project Renewal psychiatrist for three hours a day, two days a week. Travelers Safe Haven also has a part-time nurse on Tuesday for three hours, funded by DHS.

Not all clients referred for psychiatric assessment keep the appointment. In October 2016, 22 of the 41 Project Renewal psychiatric referrals (54 percent) at the Drop-In Center were kept. Also, in October 2016, 13 of 27 Project Renewal psychiatric referrals (48 percent) at Travelers Safe Haven were kept.

Mental Health Diagnosis and Treatment
Clients diagnosed with a mental illness are prescribed medication, either by the Project Renewal psychiatrist or an outside psychiatrist. Case managers counsel the client on medication. Drop-In Center clients must turn over medicine to the nurse who secures it and monitors medication with case managers. This differs from Safe Haven clients who manage their medicine unless the nurse deems them incapable. Case managers check-in with clients who are medication noncompliant or behaving erratically. There may be a case conference or psychiatrist follow-up for those noncompliant.

<u>Recommendations</u>
Last year, the City launched Home-Stat to better identify, engage and transition street homeless individuals. To make Home-Stat truly count, the City must enhance reporting and investment in mental illness, which disproportionately affects these individuals. In particular, we recommend the following.

(1) The City Should Enhance Reporting on the Mental Health Issues of Unsheltered Adults Outside the Shelter System And Regularly Assess Reports.

Given the high occurrence of mental illness and the investment the City has made in engaging this population with Home-Stat, the City should better report on and assess mental illness. Enhanced data and assessment could inform annual budget decisions, improving the cost-effectiveness of City tax levy funds on homeless services. Also, obligating providers to provide these data would not be overly burdensome given we already collect such.

In particular, we have two recommendations for Intro 932. First, Intro 932 should include mental health information for the unsheltered by type of point of service – outreach, Drop-In Center, Safe

Haven, and shelter. Breaking out information by point of service would be insightful. Namely, it would identify where we need to invest in mental health services. Intro 932 should also include a reporting requirement on the most commonly occurring mental health issues for homeless adults outside City shelters. Currently it only requires DHS to report this information for adults and children living in shelter. However, given the prevalence of mental illness in unsheltered individuals, the bill should also obligate DHS to report on the most commonly occurring mental health issues in unsheltered adults.

More data without more data assessment is insufficient though. Thus, in addition to more data, the City, in particular DHS, DOHMH, and the City Council, working with the homeless services providers, should regularly assess these data to ensure the City response in terms of services and dollars matches the population and needs. Similar to the Supportive Housing Taskforce, the City could convene a Mental Health Homeless Task Force of homeless service providers to address the intersection of homelessness and mental health as well as the needs and policy solutions. One topic for discussion could be how to improve the number of clients who keep their psychiatric referrals.

(2) DHS Should Invest More in Mental Health Services at the Drop-In Centers and Safe Havens.

DHS should invest more in mental health services at Drop-In Centers and Safe Havens. Namely, it should increase the amount in its contracts for psychiatric and nursing consultancy services. This would enable additional psychiatrist and nursing hours, which is much needed. At Safe Havens, funding for a fulltime nurse would enable each site to more thoroughly evaluate clients and address their complicated needs. A trained medical professional like a nurse brings a different set of eyes and expertise to client assessment that is necessary for the entrenched issues of the chronically homeless.

At Olivieri Drop-In Center, increasing funding for psychiatric consulting services could mean that the Thursday psychiatrist comes in for a full day instead of three hours. This could decrease the waiting list to see a Project Renewal psychiatrist. This would accelerate a client's mental health assessment, diagnosis and treatment and, in turn, them becoming housing ready with a completed 2010e. It could also lead to more clients being assessed earlier in their stay, potentially decreasing the likelihood that they do not show for their psychiatric assessment, which currently occurs.

Conclusion

Urban Pathways thanks the Committees for the opportunity to testify today. We look forward to working with the City to improve its understanding of and response to this important issue.

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New York City Council Committees on General Welfare and Health
Oversight - Part 2: Medical Health Services in the DHS Shelter System
Int. No. 929 - in relation to requiring information on health services in shelters
November 21, 2016

JOINT TESTIMONY

Homeless Services United
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Homeless Services United (HSU) is a coalition of over 50 non-profit agencies serving homeless and at-risk adults and families in New York City. HSU provides advocacy, information, and training to member agencies to expand their capacity to deliver high-quality services. HSU advocates for expansion of affordable housing and prevention services and for immediate access to safe, decent, emergency and transitional housing, outreach and drop-in services for homeless New Yorkers.

Homeless Services United's member agencies operate hundreds of programs including shelters, drop-in centers, food pantries, HomeBase, and outreach and prevention services. Each day, HSU member programs work with thousands of homeless families and individuals, preventing shelter entry whenever possible and working to end homelessness through counseling, social services, health care, legal services, and public benefits assistance, among many other supports.

The Coalition for Behavioral Health, Inc. is the largest umbrella advocacy and training organization of New York's behavioral health community, representing over 140 non-profit

community-based mental health and substance use agencies that serve more than 450,000 clients/consumers throughout NYC and surrounding counties. Coalition members provide access to the whole range of outpatient mental health and substance use services, including supportive housing, crisis, peer, employment, Personalized Recovery Oriented Services (PROS), Club Houses, education and food nutritional services, as well as many other supports that promote recovery. In addition to our policy and advocacy, The Coalition trains on average 500 human services providers monthly on cutting edge and proven clinical and best business practices thanks to generous support from the City Council, NYS Office of Mental Health, foundations and in conjunction with the NYC Department of Health and Mental Hygiene and other leaders from the behavioral health sector.

On behalf of HSU and The Coalition for Behavioral Health, I would like to thank the City Council for holding this hearing. HSU has previously submitted testimony regarding the importance of conducting a comprehensive needs assessment to identify the health, mental health and other service needs of homeless New Yorkers such that we can adequately plan for appropriate shelter capacity and service provision. We encourage the City to convene a taskforce of government and community stakeholders that includes homeless services, medical and behavioral health service providers to conduct such an assessment and identify gaps and needs as well as to better coordinate access to care.

Assessment and Treatment

Homeless Families

Though specialized shelter services for families with mental health needs do not exist, there are many homeless families who could benefit from such services. Domestic violence is the leading cause of homelessness for families in New York City. The trauma of domestic violence coupled with the trauma of homelessness can have serious repercussions for children and adults alike and can be associated with health problems such as post-traumatic stress disorder, anxiety and depression. Identifying these problems and offering access to care can greatly enhance family wellbeing which is essential to achieving other goals like securing or maintaining employment and permanent housing.

In recognition of these needs, NYC launched the Thrive initiative which is designed to help identify persons in need of services and connect them to care. Thanks to Thrive, family shelters will be staffed with licensed clinical social workers who can assess homeless families' mental health status and make referrals for ongoing clinical services as needed. While this is a welcome addition to the family shelter model, additional guidance and support on how best to integrate these staff with existing models would be helpful to ensure that we can maximize the benefit to families. Additionally, because so little data on the mental health status of families and children is available, we do not know the extent of the need and what if any additional specialized care should be offered on site or via community care. We encourage the City to collect, track and regularly report data to providers as Thrive is fully implemented so the needs of families can be appropriately assessed and addressed.

Single Adults

Persons with disabilities, including behavioral health issues are disproportionately at risk of victimization. As a City, we must ensure we are doing all that we can to enhance their safety and offer appropriate services to help them avoid or escape homelessness and maintain wellness. Unfortunately, many adults who suffer from mental illness may be reluctant to enter the shelter system out of fear.

DHS has specialized shelters for single adults in need of mental health services. More data is necessary to determine whether or not there is enough capacity to meet the needs of all individuals who require services, and which settings are most appropriate for persons with behavioral health issues. Client feedback suggests that the Safe Haven model which offers more privacy and less restrictive settings are preferred by many who would otherwise refuse shelter services. Safe Haven services should be expanded.

There are also a small number of people, who despite the efforts of homeless outreach teams and others attempting to engage them, refuse services. Outreach providers must do everything they can to respectfully engage with such persons and both respect their autonomy and honor their civil liberties while also assessing what if any danger they may present to themselves or

others. In very rare cases, it may be necessary to involuntarily remove people from the streets and refer them to hospitals or shelter services. Kendra's Law established a protocol known as Assisted Outpatient Treatment (AOT) to coordinate care for such persons but some homeless services providers have reported difficulties navigating the system, referring clients or tracking progress of those referred. We encourage DHS, DOHMH and the Health + Hospitals Corporation to work with homeless service providers to address the challenges associated with AOT and ensure all parties can effectively serve persons with acute needs.

Aftercare and community stabilization

We strongly encourage the City to move forward with implementing their supportive housing plan and with the continued use of LINC (Living in Communities) rental assistance vouchers. Critical to the success of those exiting homelessness is ensuring they have every resource and support available to them to help avoid reentry or unnecessary obstacles to housing stability. Enhanced aftercare plans for persons exiting shelter, including robust behavioral health discharge plans, are necessary so that those living with behavioral health issues have a clear pathway out of shelter with connections to services that will help them thrive in their communities as independently as possible. When appropriate and desired by the client, there should be a "warm handoff" between the trusted shelter staff worker and any community based provider, to help address the individual's or their family's mental health and substance use disorder needs. Regular information, case coordination and overall coordination on initiatives between DOHMH, HRA, DYCD, ACS and the DHS system—especially prevention, outreach and HomeBase will serve to strengthen the safety net of homeless and formerly homeless New Yorkers.

Workforce Support & Training

Homeless Services United, The Coalition for Behavioral Health and our members are fully committed to ensuring access to permanent housing to all New Yorkers in need through the provision of high quality shelter and behavioral health services. This commitment can only be fulfilled by ensuring that there are sufficient resources and budgets to meet the cost of providing these critical services. The value of what we provide to New Yorkers in crisis today, as we help restore them to becoming stably housed, is truly incalculable. However, we can start by

contracting and paying for the true costs of operating programs today. This includes cost escalations for over duration of contracts for such things as insurance, rent and other fixed costs, along with offering competitive wages to ensure retaining and recruitment of staff.

The strength of our work relies on our big hearted and highly capable staff who every day in the face of increasing demand for services step into the fear, chaos and unknown of their clients' world and bring them a ray of hope, of possibility and, most importantly show them that they are not alone in their struggles. We owe to them and their clients that they are fairly compensated, supported and trained to reflect the value of their work in society. This includes offering a living wage, regular cost of living increases, affordable benefits and education and career opportunities to create a strong pipeline of persons pursuing careers in social services.

The Coalition, through its widely recognized experience designing and delivering evidenced based behavioral health trainings and HSU with its deep operational knowledge and experience conducting trainings, welcome the opportunity to collaborate to create and deliver effective and sound trainings for the homeless services sector. In conjunction with our many partners we are confident that we can create a training academy targeting homeless program staff with a training curriculum that can fully prepare them for working with or identifying clients with behavioral health needs. We propose that the City financially support this investment to create this training academy and career pipeline for homeless services and behavioral health program staff. We would be happy to work with the Council and our government partners to realize this investment in our workers which will lead to stronger outcomes for those served by the homeless services system.

We look forward to working with the Council, administration officials and the health and behavioral health community to strengthen existing partnerships and forge new ones to promote the wellness and stability of all New Yorkers in need.

Thank you for the opportunity to testify and we look forward to working with you to create a fully resourced emergency housing and social services continuum.

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: BOUCHARD-BURNS, JEFFREY

Address: _____

I represent: NYU LUTHERAN COMMUNITY MEDICINE PROGRAM

Address: 300 SKILLMAN AVE, BROOKLYN, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 0932-2015 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Bradley Rapanut

Address: 470 E 161 St, Bronx, NY 10451

I represent: BronxWorks

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 932 Res. No. _____

☐ in favor ☐ in opposition

Date: 11/21/16

(PLEASE PRINT)

Name: Nicole Bramstedt

Address: _____

I represent: Urban Pathways

Address: 575 8th Avenue, 16th Floor
NY, NY 10008

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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: Catherine Trapani

Address: 446 W. 33rd St 6th Fl NY, NY 10001

I represent: HSU (Homeless Services United)

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: Daniel Fiefz, Chief Special Services Office

Address: HRA/DSS

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: Stephanie Gendell

Address: _____

I represent: Citizens' Committee for Children

Address: _____

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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: 11/21/16

(PLEASE PRINT)

Name: Josh Goldfein + Giselle Routhier

Address: 199 Water St 129 Fulton St.

I represent: Legal Aid Society Coalition for Homeless

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: 11/21/2016

(PLEASE PRINT)

Name: Christina Sparrock

Address: 101 Lafayette Avenue 8F, Brooklyn, NY 11217

I represent: myTime Inc

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: Dan Tietz

Address:

I represent: DCS

Address:

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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: Fabienne Laraque

Address: _____

I represent: DHS

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: Lynnette Verges

Address: 30 E. 33rd St 5th Fl N.Y, NY 10016

I represent: Care for the Homeless

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: 11/21/17

(PLEASE PRINT)

Name: Dr. Gary Belkin

Address: DOHMH

I represent: Exec. Deputy Commissioner

Address: _____

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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: Fabienne Laraque

Address: _____

I represent: DHS

Address: 33 Beaver St

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: Wendy O'Shields

Address: _____

I represent: Safety Net Activists

Address: 41 Reade Street

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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: 11-21-16

(PLEASE PRINT)

Name: Lucina Clarke

Address: 1312 E84th Street Bklyn NY

I represent: My Time INC

Address: 96003 Flatlands Ave Bklyn NY

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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: 11/21/16

(PLEASE PRINT)

Name: ~~Esther~~ Wilson

Address: 241-06 141 Ave Rosedale 11422

I represent: My Time In

Address: 9603 Flatlands Ave Bklyn 11236

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