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Testimony of

Jason Hansman, Deputy Director of Mental Health Initiatives, Crisis Response and Community Capacity

Mayor's Office of Community Mental Health

Before the New York City Council

Committee on Mental Health, Disabilities and Addictions

Committee on Hospitals

Committee on Public Safety

Committee on Fire and Emergency Management

Regarding Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan

February 6, 2023

OFFICE OF THE MAYOR
THE CITY OF NEW YORK

Good morning, Chairperson Hanks, Chairperson Lee, Chairperson Ariola and Chairperson Narcisse and members of the Committees on Public Safety; Mental Health, Disabilities, and Addiction; Fire and Emergency Management; and Hospitals. My name is Jason Hansman, and I am the Deputy Director of Mental Health Initiatives, Crisis Response and Community Capacity at the Mayor's Office of Community Mental Health (OCMH).

I'm joined this morning by my colleagues Dr. Omar Fattal, System Chief for Behavioral Health and Co- Deputy Chief Medical Officer at NYC Health + Hospitals (Health + Hospitals); Chief Michael Fields, Chief of Emergency Medical Services at the Fire Department; Chief Theresa Tobin, Chief of Interagency Operations, Chief Juanita Holmes, Chief of Training and Michael Clarke, Director of the Legislative Affairs Unit, all from the Police Department; and Jamie Neckles, Assistant Commissioner of the Bureau of Mental Health at the Health Department.

OCMH coordinates and develops citywide policies and strategies to facilitate critical mental healthcare so every New Yorker, in every neighborhood, has the support they need.

In November 2022, Mayor Adams announced a plan to create a culture of engagement for New Yorkers with untreated serious mental illness (SMI). It is clear that we have a responsibility as a city to lead with compassion and care, and that there is more we can do to help New Yorkers experiencing a mental health crisis, especially when their mental illness is so severe that they lack the ability to recognize and care for their own needs. The plan that Mayor Adams announced is an important step to delivering essential care to our most vulnerable fellow New Yorkers.

Our office had a significant role in crafting the administration's mental health involuntary removal policy and has an ongoing role in coordination across these agencies. I'm happy to testify before you today to discuss Mayor Adams' recently announced plan, including his policy regarding involuntary removals.

Mental Hygiene Law – 9.41 Removals and 9.58 Removals

New York State Mental Hygiene Law allows for individuals to be removed from the community to a hospital for evaluation by medical and psychiatric professionals who can assess the need for admission and treatment. The policy the Mayor announced in November draws on two of the Mental Hygiene Law's provisions that grant this authority: Sections 9.58 and 9.41.

Section 9.41 authorizes a police or peace officer to remove an individual who appears to be mentally ill and is conducting themselves in a manner likely to result in serious harm to self or others from the community to a hospital to receive a psychiatric evaluation.

Similarly, Section 9.58 authorizes Designated Clinicians on mobile crisis outreach teams – which can include licensed psychologists, registered professional nurses and certain social workers – to direct the same kind of removal for evaluation at a hospital.

Importantly, these Sections (9.41 and 9.58) only authorize a removal to a hospital, where a physician then conducts an evaluation to determine if the individual should be hospitalized. They do not allow for Designated Clinicians or police or peace officers to order the involuntary hospital admission of any individual.

New York State Guidance

In February of 2022, the New York State Office of Mental Health (OMH) issued interpretative guidance stating that both Sections 9.41 and 9.58 authorize the removal of an individual who appears to be mentally ill and displays an inability to meet basic living needs, even when no recent dangerous act has been observed. Their guidance was intended to help clinicians and other community providers make thoughtful, clinically appropriate determinations relating to involuntary removals, while at the same time respecting an individual's due process and civil rights. The City concurs with OMH on their interpretation.

Mayor Adams' Plan

Before this plan, these removals were done without a coordinated approach across agencies – first responders and clinicians often followed their own protocols, that were usually unknown to one another. With the Mayor's new policy, everyone is working off the same playbook, ensuring our most vulnerable individuals have an opportunity to be connected to life-changing and saving care.

As the Mayor said in November – "Job One" is as follows: New York State Law allows us to intervene when it appears that mental illness is preventing an individual from meeting their basic human needs. We must make this universally understood by outreach workers, hospital personnel, and police officers.

To that end, the Mayor's new DOHMH, FDNY-EMS, and NYPD Directive does two things:

1) **Creates an expedited step-by-step process for involuntary transportation for individuals in crisis; and**
2) **States explicitly that, in concurrence with OMH, it is appropriate to use this process when individuals appear to be mentally ill and unable to meet their basic needs**

Second, the Mayor also announced enhanced training for outreach workers. This training led by the New York City Health Department – in consultation with OMH – emphasizes the need for "basic needs" interventions and includes engagement strategies to try before resorting to a removal – as voluntary transport is always the goal. Training is already underway.

Third, the Mayor announced establishing specialized intervention teams. He announced a special cadre of clinicians and officers to ensure safe transport of those in need of hospitalization. These specialized teams will have training, expertise, and sensitivity to handle these complex cases.

Fourth, the Mayor announced creating a new support line staffed by clinicians from Health + Hospitals to provide support and advice to police officers in real-time, as they consider potential response to individuals with mental health needs. This hotline became operational last week.

Fifth, the Mayor announced that the City's legislative agenda includes working with State partners to amend the law to make clear that serious harm includes the harm that comes from an inability to meet basic needs because of a mental illness. This would codify court precedent to make this principle widely understood across the State. Additional legislative needs he announced were: (1) requiring hospital evaluators to consider all relevant factors, such as treatment history and recent behavior, not just how a person presents at that moment; (2) allowing a broader range of mental health professionals to perform hospital evaluations and serve on mobile crisis teams; and (3) requiring Kendra's Law eligibility screening in hospitals to help our most vulnerable New Yorkers stay engaged in treatment.

Importantly, the Mayor's plan does not call for "sweeps" of people living with mental illness from public spaces. It does not expand the powers of city personnel to transport individuals for hospital evaluation. It does not increase the reliance on police to address untreated serious mental illness. It does not allow 9.58 Designated Clinicians or police officers to involuntarily admit individuals to the hospital. And it does not represent the sole answer to fix our public mental health system. The City will be releasing a Behavioral Health Agenda in early 2023 that covers serious mental illness, youth and family mental health, and preventing overdoses

Agency Implementation

To ensure that we are doing all we can for our fellow New Yorkers, this work requires an interagency approach to maximize connections to mental health services.

All of this work starts with high quality training.

For 9.58 Designated Clinicians, DOHMH conducts a two-day virtual Section 9.58 training. Trainers include a variety of experts in mental health crisis intervention and risk assessment. At the end of this training, DOHMH confirms the trainee's credentials (licensure and employment on an approved mobile crisis outreach team) and issues a DOHMH identification with photo and letter signed by the Executive Deputy Commissioner of the Division of Mental Hygiene designating a person as authorized to direct 9.58 removals. These credentials expire every two years and can be renewed by recertifying licensure and employment. DOHMH also conducted refresher training in November focused on clinicians doing outreach on the street and subway to ensure that clinicians doing 9.58 removals understood the guidance from OMH. This included composite vignettes from

real situations involving people in experiencing street and subway homelessness. This refresher training content will be folded into the regular ongoing 9.58 designation training curriculum for all eligible clinicians working in mobile outreach teams for housed, sheltered and unsheltered individuals.

The NYPD trains officers on how to interact with people suffering from a mental health crisis starting in the academy. There, the NYPD has dedicated modules that provide officers with the skills that they need to make determinations on whether a person needs to be removed to a hospital pursuant to Mental Hygiene Law Section 9.41. This training is reinforced throughout an officer's career, through command-level training, videos, and training at the academy, including during training whenever an officer is promoted to sergeant, lieutenant or captain. Additionally, the NYPD is currently working to provide all officers with a four-day crisis intervention training, which provides an officer with more in-depth skills when responding to mental health calls. When the Mayor announced his directive, the NYPD added new training that builds upon and reinforces the training officers already receive. This training, developed in consultation with OCMH and DOHMH, ensures that officers understand the guidance from OMH. To help reinforce this training, the NYPD has also produced a training video that all officers must watch. Moving forward, the OMH guidance will be incorporated into existing training. The training for all outreach workers, hospital personnel, and police officers emphasizes the importance of using best efforts to encourage the individual to be transported to the hospital voluntarily.

To that end, when a 9.58 Designated Clinician believes that an individual may need to be evaluated at a hospital, their first responsibility is to use their clinical skills (where safe and appropriate) to work collaboratively with the individual to secure their voluntary agreement to be taken to the hospital for further evaluation. In the less common cases where an involuntary removal is necessary, the clinician will call for NYPD to assist with this process. In all of these cases, NYPD's role is to aid the individual in getting to the care they need. Working with the clinician, EMS and NYPD will effectuate a transport to the hospital. In the case of a Section 9.58 removal, the decision to remove is solely the clinician's– NYPD and FDNY follow the clinician's lead.

In the case of a 9.41 removal, once again, the NYPD's role is to aid an individual in getting to the care that they need. When officers determine that an individual is suffering from mental illness and is engaging in behavior that is likely to cause harm to themselves or others – consistent with Section 9.41 – they will work with EMS to bring the individual to a hospital, where a physician can do a comprehensive evaluation. To provide additional support to officers in the field, Health + Hospitals is providing a dedicated support line for NYPD officers as they encounter potential 9.41 situations. This support line is staffed 24/7 by behavioral health clinicians from Health + Hospitals' Virtual ExpressCare service, who can answer questions and advise officers as they determine whether circumstances truly call for the last resort of an involuntary removal. Critically, Health + Hospitals staff also provides NYPD officers with information on other appropriate community and social service resources to consider for those individuals who do not meet the criteria for involuntary removal or who might otherwise be better served in the community. Importantly, if the individual's future location is predictable

and they appear at no risk of imminent harm, Health + Hospitals might advise sending out a clinician the next day.

Importantly, the 9.58 Designated Clinician and the police officer or peace officer, in the case of 9.41 removals, can only have an individual taken to the hospital for evaluation. They cannot have an individual involuntarily admitted – that is at the sole discretion of the physician at the hospital.

Once an individual arrives at the hospital the 9.58 Designated Clinician or police officer assists them in registering and provides information about the reason for the removal to the hospital staff. At that point, the role of the 9.58 Designated Clinician, NYPD and EMS is complete. Ideally, the hospital will obtain additional relevant information on the individual by contacting family members, community providers, and outreach teams, and conduct a thorough psychiatric evaluation. If necessary, they will admit the patient following Mental Hygiene Law admission criteria. If not, they will be discharged with a discharge plan that includes follow up care and community resources.

All of this work is about ensuring that New Yorkers in psychiatric crisis get the highest level of care that the City can provide. This is truly a health-driven approach and one that is grounded in trying to connect everyone to the care that they deserve.

I thank your committees for your attention to this important topic and we are happy to answer any questions you may have.

PUBLIC ADVOCATE FOR THE CITY OF NEW YORK

Jumaane D. Williams

**STATEMENT OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS
TO THE NEW YORK CITY COUNCIL COMMITTEES ON PUBLIC SAFETY; MENTAL HEALTH, DISABILITIES, AND ADDICTION; HOSPITALS, AND FIRE AND EMERGENCY MANAGEMENT
FEBRUARY 6, 2023**

Good morning,

My name is Jumaane D. Williams, and I am the Public Advocate for the City of New York. I would like to thank the Chairs and the members of the Committees for holding this important hearing.

In a given year, one in five New Yorkers experiences psychiatric illness, and hundreds of thousands of those are not connected to care or support.[1] Those who are not receiving treatment or services for their psychiatric disabilities are more likely to be low-income people of more color. In addition to a shortage of inpatient psychiatric beds, our city is also experiencing an affordable housing crisis, forcing more and more people into the shelter system and the streets, making people experiencing homelessness and/or symptoms of psychiatric disabilities even more visible.

In response to a rise in crime rates in the subway, including two tragic and high-profile incidents where people experiencing symptoms of psychiatric disabilities pushed commuters in front of trains, Mayor Adams announced in November of last year that NYPD and FDNY would be allowed to involuntarily take people perceived as being unable to take care of themselves to hospitals. Many received this to mean they would be removed regardless of whether they pose any threat of harm to themselves or others. It also seemed that this was simply the announcement of a tactic, much less an entire plan. First, we have to make sure we are clear that mental health is not a crime, and that most people who are experiencing mental illness will not commit crimes.

Until that announcement, people experiencing mental health crises could be involuntarily detained only if they were deemed to be an immediate risk to themselves or others. Now, it was assumed based on the announcement that those perceived to be “mentally ill” and unable to care for their basic needs can be detained and forced into a hospital, even if they pose no risk of harm to themselves or others. If this is the case, it could not only be dangerous but also a waste of resources.

[1] https://mentalhealth.cityofnewyork.us/dashboard/

It is important to point out there is no evidence that court-ordered involuntary treatment in hospitals is more effective than community-based treatment.[2] In fact, Martial Simon, the man who fatally pushed Michelle Alyssa Go in front of a train while experiencing symptoms of schizophrenia, had been hospitalized at least 20 times and reportedly was upset that hospitals were discharging him before he believed he was well enough to live on his own.[3] Involuntary hospitalization also has a broad negative impact on many areas of a person's life, often leading to the loss of access to basic rights and services, including employment, parenting, education, housing, professional licenses, or even potentially the right to drive.[4]

Involving the police as the primary people to respond, or having them be present without being called, when responding to a person in mental health crisis is extremely dangerous and has had historically deadly results. The number of NYPD officers who have received crisis intervention training has dropped over the last two years, to the point where two-thirds of active-duty officers remain untrained, and the NYPD has no way to ensure that those officers who have been trained are the ones responding to 911 calls reporting mental health crises.[5] To name only one tragic story: In 2019, two police officers were dispatched to the home of Kawaski Trawick, a 32-year-old Black man experiencing a mental health crisis. Within two minutes, the officers escalated the encounter to the point that one of the officers fired four shots, killing Mr. Trawick, who did not have a gun. The officer who fired the shots had attended crisis intervention training just days prior.

Mayor Adams says that the city has a "moral obligation" to help those who have acute psychiatric disabilities, and I agree. However, merely holding a person in a hospital before releasing them into the same environment does not help anybody and in fact may make people distrustful of and less likely to seek behavioral health services. Just before that announcement, my office released a report saying how we were doing on mental health, and what we could be doing better – I did not receive any response from the administration, and all of our reports do go to the administration. If the city truly wants to fulfill its moral obligation to New Yorkers with psychiatric disabilities, it must invest in a continuum of care that everyone needs. I also want to mention that on December 1, my office sent a letter to the administration to get questions answered about many of the things that not only my office but many reporters and New Yorkers have asked, to try and see if we could flesh out if there was a fuller plan here. As of today, we have not received any response. Any continuum of care has to include affordable and supportive housing; affordable, community-based health services; accessible education; non-police responses to mental health crises; and employment. It should fund mental health support and services, not weaponize it.

I want to be clear that most communities that can access this continuum of care are generally white and wealthier. Most who cannot are generally poorer, Black and Brown, and unfortunately

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[2] https://www.bazelon.org/wp-content/uploads/2022/12/NYC-statement-final-12-12-22.pdf
[3] https://www.nytimes.com/2022/02/05/nyregion/martial-simon-michelle-go.html
[4] https://theappeal.org/nyc-mayor-eric-adams-involuntary-commitment/
[5] https://www.thecity.nyc/2022/12/12/23502195/what-happens-police-respond-mental-health-calls-edp

receive a response of police, forced hospitalizations, and arrest. So I always want to make sure that we can provide the continuum of care that's actually needed, that may include hospitalizations, but it needs to be clear what that plan is, and my hope is that with this hearing today, perhaps we can get many of the questions answered that many of us have, including mine, and hopefully my letter can be responded to shortly.

Thank you.

ADAPT COMMUNITY NETWORK [we change]

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Good morning, Chair Narcisse and members of the Committee on Hospitals, Committee on Mental Health, Disabilities and Addiction, the Committee on Fire and Emergency Management and the Committee on Public Safety. My name is Mariette McBride and I am the Senior Vice President, Strategic Initiatives at ADAPT Community Network. Over the past year ADAPT staff and I had the opportunity to provide feedback and additional insight on **Proposed Int. No 273-A**, based on our experience providing services and supporting adults and children with intellectual and developmental disabilities. Today, I would like to focus on impact this proposed bill would have on our community and those that we support.

For over 75 years, ADAPT Community Network has been a leading service provider, for children and adults with a variety of disabilities. Every day, we aim to build a more inclusive world for thousands of New Yorkers through education, technology, health, residential and recreational programs in all five boroughs. Accessible public education for all, community living for children and adults, advancement in assistive technology, and creating opportunities for employment, mark just some of our achievements in serving New Yorkers with disabilities across all five boroughs of New York City and most recently into the Hudson Valley. ADAPT supports 20,000 children and adults with disabilities and their families. Our mission, empowering people through innovative solutions, one person at a time guides all that we do. We work hard to facilitate growth and help people with disabilities reach their goals and true potential. We encourage people supported to become more independent while making meaningful connections in their communities.

The Proposed Int. No 273-A bill can make a tremendous difference and help to create safer outcomes for both people with intellectual and developmental disabilities and officers.
The bill will require the NYPD to provide officers with training related to recognizing and interacting with individuals with autism spectrum disorder (ASD). Such training would include: (i) enhancing awareness and a practical understanding of autism spectrum disorder; (ii) development of the interpersonal skills to safely respond to emergencies involving someone with autism spectrum disorder; and (iii) instruction on interview and investigative techniques to utilize in cases involving individuals with autism spectrum disorder.

Helping Police to Recognize and Understand Symptoms of Autism Spectrum Disorder

This training will give police some additional understanding of the types of symptoms and behaviors that are common in people with ASD so they can more easily recognize someone with ASD or other intellectual and developmental disabilities. It will provide police additional insight needed to better decipher the situation at hand when encountering someone with ASD and will give them the tools needed to keep all parties safe during the encounter.

Avoiding Physical Escalation by Communicating More Effectively

ADAPT's psychiatrists and staff have experienced several cases where the people that we support have been a part of intense interactions with police officers that often escalate quickly. For example, someone we support in our residential program ran out of the house. Staff quickly caught up with him and he remained calm and cooperative. 911 was called by an external party and the police intervened.

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Due to the individuals increased anxiety, the situation escalated, and the police restrained him. The person supported panicked and spit at the police creating a more tumultuous situation for everyone involved.

The training proposed in this bill will give police the tools they need to better communicate and interact with people with intellectual and developmental disabilities. People on the autism spectrum can perseverate on a topic or an issue in a manner that can be problematic for law enforcement and can be misconstrued as resisting an officer. People diagnosed with autism are also hypersensitive to lights and sounds that can cause them to act out or not communicate effectively when interacting with the police. The training will help provide the skills and adeptness needed to prevent interactions with individuals with ASD from escalating and creating unpredictable and dangerous outcomes.

Provide a General Awareness that individuals with ASD May Also Have a Co-occurring Psychiatric Disorder

Individuals with Autism Spectrum Disorder are at increased risk for experiencing one or more co-occurring psychiatric conditions such as anxiety disorder, mood disorders, attention deficit hyperactivity disorder (ADHD), obsessive-compulsive disorder (OCD), oppositional defiant disorder, Bi-Polar, Depression, and Psychological Trauma.

The training proposed in **Int. No 273-A** can help make police officers aware of the additional challenges and behaviors that a person with ASD could also have so have. This will help them to modify their interactions with these individuals so that all parties remain safe during their interaction.

Despite all our endeavors with the support of our psychiatrists and staff, it's becoming increasingly more apparent that we need the support of local government to be able to keep members of the Intellectual and Developmental Disability community safe. With the addition of this new proposed training for police officers, we believe it will prevent those with ASD and intellectual and developmental disorders to be targeted and cause to escalation. We have a shared responsibility to ensure that people with intellectual and developmental disabilities remain safe in our communities. It’s been an privilege to work on this drafted bill with Chair Narcisse and her team. Thank you for your time today, and I look forward to continuing to work with all of you in the year ahead.

Sincerely,

Mariette McBride

Mariette McBride

Senior Vice President, ADAPT Community Network

Asian American Federation

Testimony to the New York City Council
Committee on Mental Health, Disabilities, and Addiction, Committee on Hospitals, Committee on Fire and Emergency Management, and the Committee on Public Safety
February 6, 2023

Written Testimony

I want to thank Chairs Lee, Narcisse, Ariola, Hanks, and the Council Members of these Committees for holding this hearing and giving the Asian American Federation (AAF) the opportunity to testify on the Mayor's recently announced mental health plan. I am Ravi Reddi, the Associate Director of Advocacy & Policy at AAF, where we proudly represent the collective voice of more than 70 member nonprofits serving 1.5 million Asian New Yorkers.

This conversation is coming at a critical time for our city. In the Asian community, mental health is top of mind in light of the continuing anti-Asian hate; post-isolation fallout for children and seniors; and the spike in poverty resulting from COVID-related unemployment.

We also come to this conversation aware of the scale of unmet mental health needs across communities of color. In the past three years - and well before them - the traumas experienced within our community and amongst all marginalized communities, and the inability of existing systems to address those traumas, have exposed the failures of government bodies and policymakers to invest in long-term, sustainable solutions aimed at supporting and rehabilitating the most vulnerable members of our community.

We understand that, particularly in the diverse pan-Asian community that we represent, mental health service delivery is nuanced and complex. For one, more than 20 Asian ethnic groups are represented within our city, speaking dozens of languages. In addition to the logistics of mental health service delivery required in a crisis, cultural stigma around mental health adds an additional layer of complexity to service delivery. Furthermore, the shortage of linguistically and culturally competent mental health practitioners, which is particularly egregious in specialty areas, highlights the urgency to address these gaps and ensure that our community has equitable access to mental health services that cater to their unique needs.

One way to bridge these gaps and meaningfully address these challenges is to invest in and resource community-based organizations, who are often the first points of contact for vulnerable community members experiencing mental health crises, as well as their families navigating these crises. However, the Mayor's plan to expand the definition of who can be involuntarily removed from public spaces and to allow first responders and health care professionals to involuntarily bring to a hospital anyone who appears to be a danger to themselves "due to an inability to meet their basic needs" is dangerous and will only perpetuate a broken system that does not substantially treat unhoused and other vulnerable individuals in the long-term.

Instead, we urge the City Council to focus on and partner with those entities that are best-suited to address the urgent mental health needs of our most vulnerable community members - our community-based organizations. There has long been an under-investment in community mental health services aimed at communities of color, who often have to shoulder the burden of a healthcare and justice system that cares

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more about removing mentally ill individuals from the public eye than treating and supporting them to the point of real recovery. Policymakers must shift the focus; our community-based mental health providers must be given the resources to lead the response to mental health crises and to contribute to a system of care that does not lean on law enforcement and first responders as the first points of contact, neither of which is equipped to respond to such situations.

The current mental health crisis is shedding light on the significant lack of support for the critical community-based mental health services that community members depend on, within the Asian community and across other communities of color. For example, Asian-led, Asian-serving organizations continue to struggle to receive the funding they need to provide services the way our community members best receive them. From Fiscal Year 2002 to 2014, the Asian American community received a mere 1.4% of the total dollar value of New York City's social service contracts. Our analysis showed that over that 12-year period, the Asian American share of DOHMH funding was 0.2% of total contract dollars and 1.6% of the total number of contracts.

The City Council, led by the committees here today, must invest critical dollars in supporting community-based mental health providers. We look forward to engaging with all of you on this matter further. Thank you for allowing us to provide testimony to highlight the critical need for mental health investment in the Asian community and other communities of color.

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Presented before

New York City Council

Committees on Public Safety, Mental Health, Disabilities and Addiction, Fire and Emergency Management, and Hospitals

Oversight Hearing on Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan

February 6, 2023

My name is Danielle Regis and I am a Supervising Attorney in the Mental Health Representation Team of the Criminal Defense Practice at Brooklyn Defender Services (BDS). I have represented people in the Brooklyn Mental Health Court since 2018. I would like to thank the Committees on Mental Health, Disabilities and Addiction, Fire and Emergency Management and Public Safety for the opportunity to testify today about mental health involuntary removals and Mayor Adams' psychiatric crisis care legislative agenda.

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

BDS' Mental Health Representation Team consists of specially trained attorneys and social workers who are experts in working with and for people who have been accused of a crime and who are living with serious mental illness or a developmental disability. We are proud of having

played an important role in the creation of the Brooklyn Mental Health Court in 2002. The Brooklyn Mental Health Court works with people accused of crimes who have serious and persistent mental illnesses, linking them to long-term treatment as an alternative to incarceration. BDS continues to collaborate with this court to advocate for its expansion to meet the needs of more people, including people with intellectual disabilities and people who have previous criminal legal system involvement. Outside of court, we also help people apply for benefits and supportive housing, access mental health and substance use treatment, and locate beds in respite centers and safe havens–as we know that access to services can help people avoid court involvement altogether.

Public Focus on Mental Illness and Crime

It is nearly impossible to divorce conversations about mental health from the criminal legal system. The media and public discourse have conflated the two–creating a false narrative which links mental illness to increased rates of violence.[1] This damaging and unfounded messaging exacerbates social stigma and reduces public support of policies that create alternatives to incarceration and the policing of mental illness.[2] With his proposed psychiatric crisis care legislative agenda, Mayor Adams seeks to deploy the NYPD to forcibly remove people who appear to be experiencing symptoms of mental illness from our communities, streets, and subways. This proposal includes detaining people simply because they do not have the economic resources to meet basic human needs–sweeping people up because they are a "risk to self" due to inability to afford treatment for an injury, wear appropriate clothing, or access stable housing. We fear this plan will increase contact between NYPD and both people living with mental illness and people who are unhoused, and will escalate tensions between the person being forcibly removed and the police. These situations will result in unnecessary forced hospitalizations, or arrests and the criminalization of resisting transportation to a hospital.

New York relies largely on policing and incarceration to address issues related to mental health and substance use. The rollout of non-police responses to mental health crises across New York City have been slow.[3] Police, rather than medical providers, are most likely to respond to people experiencing a mental health crisis.[4] Instances where the police respond to mental health crises

[1] Heather Stuart, Violence and mental illness: an overview, World Psychiatry, June 2003, Available online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525086/
[2] *Id.*
[3] Greg Smith, Cops Still Handling Most 911 Mental Health Calls Despite Efforts to Keep them Away, The City, July 22, 2021, Available online at https://www.thecity.nyc/2021/7/22/22587983/nypd-cops-still-responding-to-most-911- mental-health-calls
[4] National Alliance on Mental Illness, Jailing people with mental illness, 2019, Available online at https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Jailing-People-with-Mental-Illness.

often end in abuse or even death.[5] In his new plan, rather than trying to reverse this trend, Mayor Adams has called on the NYPD to conduct more involuntary removals and has given police even broader discretion when determining if someone is at risk of harm to themselves or others.[6]

During the height of the COVID-19 pandemic, inpatient psychiatric beds were eliminated and outpatient programs were forced to move to remote formats. People who are living with mental illness who previously struggled to access or remain connected to care were left with even fewer resources. As we emerge from the depths of the pandemic, the supply of inpatient psychiatric beds and availability of outpatient programming remains inadequate to meet the need.[7] The Council must work with the community to restore—and expand—access to mental health care for New Yorkers.

Policing, Instead of Treating, a Mental Health Crisis

The Mayor's response to the mental health crisis relies on a short-term emergency response which will not meet the short- *or* long-term needs of people living with mental illness. Forcibly removing people perceived to be mentally ill from the street to the most restrictive setting is not only inhumane, it also ineffective in facilitating the goal of engaging people in mental health treatment.

Forcible removals by the police entail a risk of danger to the person who is experiencing a mental health crisis. When police respond to calls related to mental health crises, they are frequently not trained nor prepared, which is why these calls commonly result in harmful, if not fatal, outcomes. These interactions with police do not result in obtaining proper care for the person in crisis—but rather, the opposite happens. These interactions routinely result in handcuffs and incarceration. "It's why some U.S. jails hold more people with serious mental health conditions than any treatment facility in the country."[8] These interactions also make people vulnerable to police violence; in 2021, at least 104 people across the country were killed after police responded to someone "behaving erratically or having a mental health crisis." [9]

Even when police are properly trained, the simple presence of an armed police officer can escalate tension and trigger anxiety and distress for those who are living with mental illness or behavioral health conditions. As public defenders, we have seen firsthand how police interactions play out all too often. Our most recent cases confirm that an increase in police encounters with those living

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

[6] Office of the Mayor, Mental Health Involuntary Removals, November 28, 2022, Available at https://www.nyc.gov/assets/home/downloads/pdf/press-releases/2022/Mental-Health-Involuntary-Removals.pdf

[7] Bahar Ostadan, Patients Familiar with NYC Mental health System Skeptical of New Adams Policy, *Gothamist*, December 2022, Available at https://gothamist.com/news/patients-familiar-with-nyc-mental-health-system-skeptical-of-new-adams-policy

[8] *Id*.

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

with mental illness are not resulting in removal to a hospital or care facility, but are instead resulting in arrest, incarceration, and further decompensation.

One person we represent, Ms. C, was visibly experiencing grief and anxiety after she learned that a family member had died. At that moment, NYPD officers who were on patrol saw her and–because they believed she was in an acute crisis–immediately put her in handcuffs. When Ms. C tried to ask why she was being handcuffed, the officers claimed she was resisting arrest and later claimed she kicked one of the officers. She was brought to the local police precinct, where she suffered an anxiety attack, and was brought to Kings County Hospital. At the hospital, she was handcuffed to a hospital bed, surrounded by police for hours, and then brought to court for arraignment. Ms. C was charged with resisting arrest and a felony assault. The prosecution requested she be held on bail at Rikers Island, but fortunately, the judge released her under supervised release. After two court dates, and two check-ins with her supervised release program, her case was Adjourned in Contemplation of Dismissal (or ACD). Ms. C had no record and had never been arrested before this incident. This experience was incredibly traumatic and further exacerbated her anxiety and ability to grieve the loss of her family member.

When Mr. K, a young person we represent who lives with a mental illness, was experiencing a mental health emergency, his mother called 911 to request an ambulance to bring him to the hospital for mental health care. When the EMTs arrived, they were accompanied by a police officer who rode with Mr. K in the ambulance (a requirement under the Mayor's plan). While Mr. K was being transferred from the stretcher to a hospital bed, he was accused of headbutting the police officer at the hospital bedside. Mr. K was then arrested for a felony assault, handcuffed to the hospital bed, and brought to arraignment court the next day. His attorney successfully advocated for his release. Later, he met with his Assertive Community Treatment (ACT) team, where he was stabilized on his medication. Since then, his criminal charges have been reduced to a misdemeanor, and his attorney is working to have his case dismissed.

In New York, when someone is accused of assaulting a police officer, the charges are elevated from what would otherwise be a misdemeanor to a violent felony. That means that judges can set bail on these cases, sending more people with mental illness to jails that are already ill-equipped to care for them. Rates of self-harm and suicides have skyrocketed inside New York City jails. As we have repeatedly said, the level of crisis in the jails cannot be overstated. People are suffering and dying. They are enduring mental health and medical crises without access to medication or care. People in custody—including those with no preexisting conditions—are experiencing rapid deterioration of their physical and mental health. With units going unstaffed, New Yorkers are left crying out for help while locked in a cell with no officer at their post.

We are concerned that an increase in interactions between police officers and those living with mental illness or behavioral health issues will result in unsubstantiated assault allegations and send more people to jail instead of helping them access the care they may need.

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The Mayor's Plan Fails to Address the Root Causes of Mental Health Emergencies

In his rollout of his legislative plan, the Mayor conjured images of people experiencing street homelessness. He cited conditions related to poverty–riding the train to the end of the line, not wearing shoes in inclement weather–as markers of a mental illness and reason for police intervention. People living with SMI are more likely to experience homelessness, and the extreme stress and trauma of homelessness exacerbate existing mental illness or may cause a trauma exposure response. Forced hospitalization, however, does not help someone find a stable home. Physical and mental health outcomes are worse for people who struggle to meet their basic need for shelter, food, and safety. Investment in housing, social safety net programs, and free, voluntary mental health care is needed to address the Mayor's concerns.

Involuntary removals are inherently traumatic. People are torn from their homes, communities and support systems. For people experiencing homelessness, their belongings are often lost or thrown away. This forcible–often violent–removal creates a traumatic association with the hospital, a place that should be associated with access to treatment and care, not punishment. Involuntary removals create an additional barrier to care for people when they are ready and able to opt into treatment. People we serve who have a history of involuntary hospitalizations have shared with us that they avoid the hospital, even when they recognize they need critical mental or physical health treatment, because of a fear of loss of autonomy, forced treatment, and an association with a past traumatic event. Living with a mental illness is not a crime; New Yorkers must be provided the opportunities and resources to choose care without coercion.

Recommendations

Many of the people we represent have tried to access mental health treatment for years. Others have endured psychiatric hospitalizations but are discharged back to the community without connections to ongoing treatment or stable housing. At the best of times, services are limited but in the wake of the COVID-19 pandemic, finding appropriate mental health care seems near impossible. People seeking care remain on waitlists for months or years for Assertive Community Treatment (ACT) teams, supportive housing, psychiatrist appointments, or other care they require. Many are discharged from psychiatric hospitalization with a referral to first-come-first-serve walk in mental health care and a list of congregate shelters. Some are denied services for requiring a "higher level of care" or having a co-occurring substance use disorder. With no information on where to turn next, people with mental illness who are seeking care are often met with police, arrest, and incarceration.

Investment in the mental health of New Yorkers must include community-led mental health initiatives, increased access to long term mental health care, supportive housing, and programs that seek to minimize community violence and mitigate trauma exposure response. BDS respectfully offers the following recommendations:

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1. Remove NYPD from mental health emergency responses

For years, BDS has called for the removal of NYPD from all mental health responses, including mental health emergencies, and the expansion of mobile crisis teams. The City has attempted to change the response to serious mental illness (SMI) through piecemeal legislation and pilot programs. As we feared, in the neighborhoods where mental health teams are being piloted, NYPD officers are still responding to mental health emergencies in most cases.[10] Now Mayor Adams is encouraging officers to engage further with people they believe are experiencing mental illness. Allowing the NYPD to continue responding to these calls—even with additional training—does not address the real danger that police pose to people experiencing mental health crises. This plan criminalizes mental illness. Police are not mental health experts or medical professionals, and they should not be tasked with filling this role.

The Council should fully fund mental health crisis response teams to ensure mental health emergency calls are addressed by medical professions or clinicians who are trained in de-escalation methods.

2. Stop incarcerating people with mental illness

New York City jails have long been in a state of crisis; a violent, mismanaged disaster and a stain on this city. It has been clearly documented by endless testimonies from people in custody,[11] health and correctional staff,[12] correctional experts, major newspapers and networks, and by a federal monitor who has released over a dozen reports.[13] The level of crisis in the jails cannot be overstated.

DOC's mismanagement of its staff, primarily its failure to provide access to mental health appointments and critical services, is dangerous and has proven to have fatal outcomes. We know that many people in custody enter the correctional system with risk factors for self-harm such as having a history of trauma, mental health issues, and/or substance use.[14] Despite policies and

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

[11] Rebecca McCray, What It's Like at Rikers, According to People Who Just Got Out: "They're not feeding people, there's no water, no showers, no phone calls," *New York Magazine, Sept. 23, 2021,* Available online https://www.curbed.com/2021/09/rikers-jail-conditions.html.

[12] Gloria Pazmino, Staffing Dysfunction and Unsafe Conditions lead to Crisis on Rikers Island, NY1, September 9, 2021, Available online https://www.ny1.com/nyc/all-boroughs/public-safety/2021/09/10/rikers-island- staffing-issues-correction-officers-calling-out-unsafe-conditions-what-happened.

[13] All Nunez Monitor Reports are available online at https://www1.nyc.gov/site/doc/media/nunez-reports.page

[14] Laura Frank and Regina T.P. Aguirre, "Suicide Within United States Jails: A Qualitative Interpretive Meta-Synthesis," Journal of Sociology and Social Welfare XL, no.3 (2013): 31-52; Doris J. James and Lauren E. Glaze, Mental Health Problems of Prison and Jail Inmates (Washington, DC: U.S. Department of Justice, Bureau of Justice

efforts by correctional health clinicians to provide medical intake services, medication, and schedule recurring appointments, the Department is a regular barrier for people in custody to access essential treatment and care.

We urge the City and this Council to take meaningful steps to decarcerate our jails and commit to funding programs and services that support and uplift our communities–not simply government systems that surveil, punish, and harm them.

3. Continue to provide respite centers and crisis beds for people with mental illness

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

When NYPD responds to a mental health emergency the person in crisis is handcuffed and transported to a hospital for evaluation or a police precinct. Mental health teams, on the other hand, have begun to move away from this practice by providing care in the community, outpatient referrals, and bringing people to crisis respite centers.[15]

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

4. Close treatment gaps for individuals with serious mental illness

We recognize a need for high quality, trauma informed therapy and psychiatry services for adults with SMI. Inadequate community-based mental health and substance use treatment funnels people struggling with mental illness into handcuffs, jails, and prisons. For these individuals, time in City jails frequently exacerbates preexisting mental illness, as behavioral health needs are all too often met with violence and isolation rather than appropriate care. After serving time in jail or prison,

Statistics, 2006, NCJ 213600); Henry J. Steadman, Fred C. Osher, Pamela Clark Robbins, Brian Case, and Steven Samuels, "Prevalence of Serious Mental Illness Among Jail Inmates," Psychiatric Services 60, no.6 (2009): 761-765.

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

people return to their communities frequently lacking adequate healthcare infrastructure and access to affordable and supportive resources. These inadequacies lead too often to tragic results–either irreversible sickness and death or the churning cycle of incarceration, lapses in treatment, homelessness, and rearrest.[16]

The Mayor's plan relies upon the highest level of care – Assisted Outpatient Treatment (AOT) and Kendra's Law. While many of our clients have thrived with Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) teams, this level of intervention is not needed for many people living with SMI. To ensure that every New Yorker is able to access the care they need, we ask that the City expand evidenced-based treatments available to people with severe mental illness before they become involved in the criminal legal system. This includes expanding access to Intensive Mobile Treatment Teams (IMT); investing in community based mental health treatment programs in low-income communities; expanding access to Article 31 and Article 32 clinics; and educating frontline workers on available mental health care options for New Yorkers with SMI. Free, voluntary mental health care must be made available in communities with the highest rates of mental health calls to EMS and must be expanded to include longer hours to reduce instances where people are turned away when seeking help.

The City must ensure that these programs are sufficiently staffed and that providers receive appropriate compensation. Intensive Mobile Treatment (IMT) Team and peer based support systems have been imperative, on the ground support for the people we serve. Providers must earn a living wage and the City must work to retain seasoned providers.

5. **Fully fund the Mayor's Office of Criminal Justice (MOCJ) reentry hotel program**

In April 2020, the City of New York partnered with direct service providers to establish the Emergency Reentry Hotel Program to provide emergency housing for people transitioning out of incarceration. With co-located wrap-around services including medical care, case management, and housing and vocational support, people returning to the community had a safe, stable place to stay. This setting has proven to be life-changing for many of the people we serve, particularly those living with SMI. In lieu of loud, chaotic and often violent congregate shelters, people have private rooms in clean, comfortable buildings where they are treated with dignity and respect. In the first two years of the program from March 2020 to 2022, over 2,100 returning to New York City from prison or jail have been served by this program.

The current emergency hotel program is scheduled to close on June 30, 2023, with the 530 current residents being moved into transitional housing. This plan, however, fails to serve the goal of using

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

transitional housing to decarcerate Rikers Island. As of February 2, 2023, there are over 375 people on a waitlist for a bed in the emergency hotel program–many of whom are incarcerated only because they do not have stable housing. The Council has a moral imperative to continue to fund this critical program as a step in a continuum of reentry housing.

6. **Expand access to permanent supportive and affordable housing**

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

The City must work to expand access to supportive housing for people with SMI or substance use disorders, as well as ensure access to affordable housing for all.

7. **Courts should increase the use of supervised release or ATD programs for people living with mental illness**

As mentioned above, the population in the City jails continues to grow despite the current crisis inside the jails. The City Council should urge the courts to stop the pipeline of New Yorkers into the jails, and increase use of supervised release, alternatives to detention (ATD) programs, or—when medically indicated—hospitalization, particularly for people with SMI charged with bail eligible cases.

Judges of the New York City Criminal Court are appointed by the mayor. The Mayor and the Council must hold judges accountable for ensuring the proper implementation of the bail laws and the public safety of New Yorkers—including those who have been accused of a crime. The City Council should strongly remind courts and DAs that bail should not be used to detain, but rather, to incentivize people to return to court. The Council should demand that judges and DAs are regularly using and offering all available options. ATD programs are available but underutilized and the City Council should encourage courts to order these programs more regularly and district attorneys to consent. Jail is not an appropriate place for people with histories of mental illness. Courts should regularly order, and district attorneys should regularly consent to, these alternatives to incarceration.

8. **Pass a New York City Resolution in support of the Treatment Not Jail Act**

The City Council should call on the legislature to pass and the Governor to sign the Treatment Not Jail Act, S.2881B (Ramos)/A.8524 (Forrest).

In 2009, as part of the Rockefeller Drug Law Reforms, New York State passed the Judicial Diversion Program legislation. Under Criminal Procedure Law Article 216 (CPL 216), this legislation created a pathway for a small subset of people with substance use disorders to avoid prison and potentially have their charges reduced or dismissed after engaging in a course of treatment. This treatment is monitored by specialized courts in every county in New York. Judicial diversion has successfully enabled thousands of individuals to minimize or avoid a criminal record while receiving the benefit of potentially lifesaving substance use treatment. Judicial diversion has also realized the saving of tax dollars, from both reductions in reoffending and the decreased costs per capita of treatment versus incarceration.

Unfortunately, CPL 216 diversion is limited to people with substance use disorders charged with a short list of crimes related to substance use. The current law leaves behind people who do not live with substance use disorders, but experience other mental illnesses, developmental disabilities, or cognitive impairments that can be effectively addressed through treatment. People living with mental health issues deserve treatment, not jail. Mental health intervention through courts can decrease the jail population and provide people with access to treatment they would not receive if incarcerated. This has been shown to increase mental health program enrollment and completion of these programs reduces homelessness, psychiatric hospitalizations, and rates of recidivism.[17] New York can become a leader in diverting people with mental health issues out of the criminal legal system and into treatment by passing the Treatment Not Jails Act.

Conclusion

The City cannot arrest and involuntarily hospitalize its way to mental wellness and public safety. People experiencing mental illness deserve access to housing and treatment in a non-coercive manner. Involuntary commitment and an expansion of Kendra's Law are not the answer. The city should work to expand evidence-based treatment programs, services, and housing to address the needs of New Yorkers living with mental illness. BDS urges the City Council to work with the Mayor to invest in the continuum of stable and safe housing–including reentry hotels, respite programs, and permanent and supportive housing–that are the foundation of any mental health treatment plan. The city must move away from a mental health response that police and criminalize people and move towards real community investment and community-based responses. We

[17] Nazisha Dholakia and Daniela Gilbert, What Happens When We Send Mental Health Providers Instead of Police, Vera Institute of Justice: Think Justice Blog, 2021, Available online at https://www.vera.org/blog/what-happenswhen-we-send-mental-health-providers-instead-of-police.

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encourage you and the Mayor to work collaboratively with community-based organizations, people with mental illness and their families, as well as defenders and advocates, to create real solutions. We look forward to partnering with you and continuing this important conversation.

Thank you for the opportunity to testify today. If you have any additional questions, please reach out to Kathleen McKenna, Senior Policy Social Worker at kmckenna@bds.org.

Testimony:

Good morning (Afternoon), Chairperson Lee, and members of the Committee on Mental Health, Disabilities, and Addiction—the Committee on Hospitals, the Committee on Fire and Emergency Management, and the Committee on Public Safety. My name is Alexandra Nyman and I am a new York city resident and I serve as the CEO of the Break Free Foundation. Thank you for the opportunity to testify against involuntary hospitalizations for matters of mental health as outlined in Mayor Adam's recently announced plan.

It is my firm belief that involuntary mental health hospitalizations create obstacles to quality, evidence-based mental health care by creating a fear of forced treatment, and fraying a person's trust in the health care system. Being forcefully hospitalized is one of the most traumatic things an individual can experience.

A family member of mine went through this when they were in college due to being in a mental health crisis, and being confronted by an officer, instead of a mental health professional, did not remedy the situation, but intensified it. This confrontation resulted in them having a severe panic attack as the officer was not equipped to de-escalte the situation, but kept escalating things to a point that my family member did not feel safe.

After the officer called an ambulance, my family member was informed that the first hospital they arrived to did not have proper mental health services. They were then rerouted to a second hospital that had the proper faciltites they required. My family member was terrified, wondering how much this ride would cost them, which is the last thing a person experiencing a mental health crisis should be worrying about.

Instead of finding relief during their hospitalization, for the first twenty-four hours they sat on a stretcher in the hallway waiting for an open room getting little to no sleep. When they got into a room and were admitted into the behavioral health unit, they were lumped in with patients of varying mental illnesses. There was chaos in the halls, screaming rang throughout the quarters, with medication shoved down their throat.

This created a resistance to treatment for months afterwards, and shut my family member down from talking about the experience until after years of intensive therapy. While my family member did not have a co-occurring disorder - which further exasterbates this issue - and is not an unhoused individual, they were not given the qualitative treatment they needed. I am lucky that they are still here with us and that they are in recovery.

People who struggle with behavioral health issues are marginalized and face stigma that can lead to severe consequences. Chairperson Lee and members of these esteemed committees, you must realize that this policy perpetuates the belief that many people hold that individuals with mental health issues are dangerous. But in reality, they are more likely to be victims of crime and excessive use of force by the police than to cause harm.

I urge this committee to put an end to this policy, in the words of my esteemed colleague, Matt Kudish, the CEO of the New York chapter of NAMI, “The City has the power to provide onsite treatment, as well as treatment in homeless shelters or supported housing, but has chosen not to.”

The time to make these changes and to address the mental health crisis within our city is now. But causing generational trauma in the process and resistance to behavioral health care is not the way to go about it.

Thank you for the opportunity to testify today, and for your continued leadership and partnership.

Committee on Mental Health, Disabilities & Addiction,
Jointly with the Committee on Hospitals, Committee on Fire & Emergency Management,
and Committee on Public Safety

Oversight: Mental Health Involuntary Removals and
Mayor Adams' Recently Announced Plan

Good Morning, Chairs Lee, Narcisse, Hanks and Ariola, and members of the Committees on Mental Health, Disabilities & Addiction; Hospitals; Fire & Emergency Management; and Public Safety. I'm Nadia Chait, the Senior Director of Policy & Advocacy at CASES. CASES served over 1,500 New Yorkers last year living with serious mental illnesses. The majority were experiencing or had previous experiences of homelessness. Many also have a long history of negative experiences with police and the criminal-legal system, consistent with our City's ongoing criminalization of mental illness.

We oppose the Mayor's directive, which threatens many of the community members currently engaged in our services with involuntary commitment and increased interaction with the criminal-legal system. Our City's mental health system has long been inadequate. **Forty percent of New Yorkers with serious mental illness did not receive mental health treatment** within the most recent year for which data is available.[1] Sixty-two percent of New Yorkers with depression did not receive mental health treatment in the most recent year for which data is available.[2] We should not respond to that failure by penalizing those who have been most directly harmed by the City's inability to provide care. Involuntary commitment should be a last resort when all other options have been exhausted, not a first step.

We are deeply concerned by the continued use of police as first responders to mental health crisis. Police do not have the training or expertise to handle these emergencies, which should have a healthcare response just as other healthcare emergencies do. It is particularly critical to reduce the reliance on police given the crisis on Rikers. We fear that increased policing of our clients could lead to their incarceration on Rikers, an inhumane institution that is unable to provide even the most basic safety to incarcerated individuals. Last year, 19 individuals died on Rikers, including seven who died from suicide and six who died of overdose. Increased criminalization of mental illness threatens our clients' recovery and their lives.

We agree with the Mayor that more must be done to help New Yorkers with serious mental illness. **We must invest in the proven solutions that promote recovery.** New Yorkers with mental illness need the right intervention, at the right time, and the right dose. By increasing access to programs that work, we can help people with serious mental illness to access recovery and healing, in the community.

Eliminate the Waitlist for Intensive Mobile Treatment

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[1] New York City Department of Health and Mental Hygiene. Serious Mental Illness among New York City Adults. June, 2015. https://www1.nyc.gov/assets/doh/downloads/pdf/survey/survey-2015serious-mental-illness.pdf
[2] New York City Department of Health and Mental Hygiene. Depression Among New York City Adults, April 2018. https://www.nyc.gov/assets/doh/downloads/pdf/survey/depression.pdf

When people are offered the right mental health service, they are not only willing but happy to engage in care. CASES currently operates seven Intensive Mobile Treatment (IMT) teams, which each have peer specialists, behavioral health specialists, psychiatry and nursing. These teams provide wraparound support to individuals who have serious mental illness, are homeless or were recently homeless, and have criminal-legal system involvement. These are people who have been repeatedly failed by the systems that are supposed to help them and left on their own with little support. IMT allows us to meet these individuals where they are.

IMT is a voluntary service. People are not mandated into the program and have no obligation to engage. But mandates are not necessary, because we find people want to engage in care. IMT is one of the only mental health programs that funds outreach to clients. Through this, we are able to educate clients about the services available to them and build trusting relationships. People want to engage with us. They want help with their mental health, with housing, with pending court cases and the many other services we offer.

Access to IMT is limited, however, by the number of teams. Currently, there is a 600-700 person waitlist for IMT services. The City does have an RFP out to add 5 additional teams, which will serve 135 people total. This is a step in the right direction, but not enough to eliminate the waitlist. The City should fund an additional 20 IMT teams to fully eliminate the IMT waitlist. Each team costs just $1.5 million per year and serves 27 people. This is a very cost-effective intervention, far less per person than the $550,000 the City spends to incarcerate someone on Rikers for a year. Unlike incarceration, IMT promotes recovery, increases access to housing, and provides treatment.

Increase Funding for Mental Health Clinic Services

CASES' mental health clinic, with locations in Harlem and the South Bronx, provides a variety of treatment options for community members with mental illness. We are one of the only mental health clinics in New York City, and the only one in Harlem or the South Bronx, that provides dedicated mental health services to people with criminal-legal system involvement. People seek out these services voluntarily – over 15% of our referrals come from the individual directly (self-referral). We also see many people referred to our clinic from CASES' other, non-mental health programs (27% of referrals), where people who might not have previously been aware of mental health services learn about what is available. These people make the decision to voluntarily engage in our services, once they know what help is available.

CASES serves about 1,000 people annually in our clinic. 67% of clinic clients identify as Black and 34% identify as Hispanic. The most common diagnoses are depression, PTSD, schizophrenia, and bipolar disorder. Many of our clients also have substance use disorders. We use evidence-based strategies to help our clients, including DBT (dialectical behavioral therapy). DBT is recognized as a promising intervention for adults and youth with multiple challenges, with research finding improvements in symptoms related to depression, anxiety, emotional regulation, violence and substance use.

Unfortunately, funding for the CASES clinic is woefully inadequate. We currently operate at an annual deficit of $700,000 per year, and we are not sure how long we will be able to keep the clinic open. We had temporary funding through the federal Substance Abuse and Mental Health Administration (SAMHSA) to implement the Certified Community Behavioral Health Clinic (CCBHC) model, which provides enhanced funding to organizations that provide high-quality, integrated mental health and substance use care. This funding stabilized our clinic's finances and

allowed us to provide, in one location, the holistic services our clients need, including mental health counseling, substance use services, case management and peer support. Governor Hochul has committed to expanding CCBHCs in New York as part of her budget, which we strongly support. We are hopeful the CASES clinic will be one of the expanded CCBHCs. However, we encourage the Council and the Mayor to also identify funding streams targeted to programs that serve community members with mental health treatment needs and criminal-legal system involvement. As the Mayor recently said on NY1, "close to 48% of people on Rikers Island are dealing with mental health issues, they need service and care, not incarceration." For those New Yorkers to receive service and care, the City must step up to fund specialized services like those CASES provides. Doing so is essential to fulfilling the promise of Closing Rikers and to ending the criminalization of mental illness.

Establish Community Care Vans to Close Treatment Gaps

CASES provides pretrial services to all eligible defendants age 16 and older facing trial in New York County (Manhattan), regardless of where they live. Our supervised release program works with people to ensure they return to court and to connect them to helpful services. The data indicates that CASES Pretrial Services are very successful. The majority of CASES Pretrial clients (86% in FY21[i]) make their court appearances successfully, without having a warrant issued for failure to appear. Individuals in Pretrial Services are also unlikely to be re-arrested: 85% of our Pretrial clients are not re-arrested for a felony (and 93% are not re-arrested for a violent felony) in their first year in the program.

However, CASES has limited space at the court to introduce ourselves to clients and to start their intake process. We are often forced to have sensitive conversations on benches in public hallways, which simply is not effective for many clients. We also know that for clients who are street homeless, it can be remarkably challenging to maintain contact with us, as these clients often do not have phones or money for MetroCards. There is currently a significant gap in our behavioral health system where people with immediate mental health treatment leave court with little more than a piece of paper directing them to services on a future date.

To fill this gap, the City should fund a Community Care Van, which would be located directly outside of the Criminal Court building. The van would provide rapid-engagement services and would be available seven days/week, with extended evening hours. It would create a rapid, seamless transition from court to community. Services would include:

- immediate clinical, psychiatric and substance use intervention;
- comprehensive assessment and responsive intervention to address client needs; and
- escorts to emergency services, including crisis respite, detox, emergency housing and shelter intake.

The van would be equipped with a bathroom, shower, medical supplies and private interview spaces. Provider staff based at the van would be able to distribute care packages, including nutritional and hygienic items and clothing. We estimate each van would have a capital cost of $377,000 and annual operating costs of $2,750,000.

Improve Hospital Coordination & Create Crisis Programs

There are times that people with serious mental illness need inpatient care, just as there are times that people with physical health challenges require hospitalization. However, this step should not be taken without first providing robust access to care in the community.

The Mayor's directive also appears to ignore that there are serious challenges with inpatient hospitalization. Hospitals routinely fail to coordinate with community-based providers, neglecting to engage in even the most routine aspects of discharge planning. Recently, one of our clients was hospitalized. The social worker on his CASES team went to the hospital, spoke with hospital staff, and provided her cell phone number, stressing that she was available at any time to discuss discharge planning and care for the client. The individual was discharged two days later. The hospital never called our social worker and did not make any other attempts to contact CASES. The client was readmitted to the hospital just a day after discharge, due to failures in care coordination.

The Mayor's directive suggests that hospitals will admit the individuals who are transported to them. However, the bar for involuntary commitment is high, as it should be. Many people who need services do not qualify for involuntary commitment. Rather than relying on hospitals and emergency departments as default settings, the City should work closely with providers to expand access to Support and Connection Centers, which provide a multi-day intervention for individuals in crisis. These services are voluntary and can build long-term connections to community-based providers, so that people have the care they need after the crisis has passed.

Expand Access to Housing

We cannot expect New Yorkers to successfully manage their health and wellbeing when they do not have a roof over their heads. The Council should support the creation of transitional and permanent supportive housing for people with serious mental illness who are experiencing street homelessness. The transitional housing could be a continuation of the City's policy during the pandemic to lease hotels and place service providers onsite. This requires little upfront investment and would bring housing online immediately, rather than waiting years for new construction. Transitional housing can be very helpful for individuals with criminal-legal system involvement, who may not have lived independently for a number of years. The City must also invest in permanent supportive housing specifically designed for people with mental illness and criminal-legal system involvement.

We completely agree with Mayor Adams that the status quo is not working, and we commend the Council for holding this hearing to identify how we can better support New Yorkers living with serious mental illness. Now is the time to fully invest in programs that work and to expand access by creating new programs that reduce barriers to care. We cannot return to failed policies that rely on police and removal from the community. We urge the Council to invest in recovery and healing.

Thank you for the opportunity to testify today.

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Center for Justice Innovation
New York City Council
Committee on Mental Health, Disabilities and Addiction
Jointly with the Committee on Hospitals, the Committee on Fire and Emergency Management, and the Committee on Public Safety
February 6, 2023

Good morning Chairs and esteemed Council Members of Committees on Mental Health, Disabilities, and Addiction, Hospitals, Fire and Emergency Management, and Public Safety. Since its inception, the Center for Justice Innovation (formerly the Center for Court Innovation), referred to as 'the Center,' throughout these remarks, has supported the vision embraced by Council of a fair, effective, and humane justice system and building public safety through sustainable community-driven solutions that cultivate vibrant neighborhoods.

The Center's longstanding partnership with Council over the past twenty-five years has helped bring this vision to life through evidence-based and racially just programming that spans the entire justice continuum. Our firsthand experience operating direct service programs and conducting original research uniquely positions us to offer insights that Council can look to as it considers the development of initiatives that respond to needs of all New Yorkers. In each instance, our aim is to provide a meaningful and proportionate response, to treat all people under our care with dignity and respect, to prioritize public safety, and to produce much-needed cost savings for the City. And, as an anti-racist organization, to ensure the needs of marginalized New Yorkers are addressed.

Police, the courts, and social services must work hand in glove with a range of tools to achieve better outcomes in the long term, address health, psychiatric, and housing needs on an individualized basis, and ensure safety for all New Yorkers. For too long, we have relied upon law enforcement and jail to be our primary response to those in mental distress. Half of those held on Rikers have a mental health issue, 16% with a severe mental health issue. Yet for people with unmet behavioral health needs, an arrest—even for a low-level crime—can mean a lifetime in and out of the criminal justice system.[1] In 2017, the Center played a central role in crafting the plan to shutter the notorious jail complex on Rikers Island by coordinating the Independent Commission on New York City Criminal Justice and Incarceration Reform, otherwise known as the Lippman Commission. This achievement was a monumental step forward in the mission to reduce incarceration in New York.

However, responsibly reducing incarceration requires a long-term commitment to innovative upstream and court-based solutions, including prioritizing the upstream engagement and treatment of individuals by coordinating social services and support for mental health issues

and substance use disorders, and the expansion of access to comprehensive, quality supportive housing services to prevent homelessness. In this testimony, we highlight the Center's innovative pilot program, **Community First**, which utilizes a Community Navigator model to voluntarily connect individuals who are experiencing homelessness, to a continuum of social services so they can transition off the street.

The Center also engages individuals intersecting with the justice system to ensure they are properly supported and prevent continued cycling through often harmful systems. The Center's Midtown **Misdemeanor Mental Health Court** is a specialized court targeting low-level offenders living with a serious mental illness related to their criminal justice involvement. This work began in February 2022, through an unfunded mandate of the Office of Court Administration (OCA). This year alone, the Center is seeing an increased need for misdemeanor alternatives to incarceration across our court-based programs. To address rising caseloads, the Center seeks $1.7 million in Council support for misdemeanor diversion, including funding to support the Midtown Misdemeanor Mental Health Court.

Additionally, to continue executing services across the City, the Center stands ready to work with Council to address payout delays across City agencies, such as the Mayor's Office of Criminal Justice (MOCJ), where delays for payment of contracted work continue, and subsequently delay service delivery and place strain on Center program operations and staff lines.

Upstream Intervention; the Community First Model

In 1993, Midtown Community Court, a project of the Center, opened its doors to address low-level crimes and violations that defined the Times Square/Hell's Kitchen neighborhood at the time. Over one-quarter of a century later, the Midtown Community Court works with some of Manhattan's most vulnerable individuals—those who are homeless, battling mental illness and/or substance use disorders—in community, to prevent involvement with the criminal justice system and ensure their needs are met. Poverty, housing insecurity, unemployment, the justice system, and now COVID-19, disproportionately and devastatingly impact this population. The Times Square Alliance (the Alliance) approached Midtown Community Court to implement a solution that offers a more holistic approach. With seed funding from the Alliance, Community First launched in April 2021, in partnership with two additional social service organizations: Breaking Ground and Fountain House.

Midtown Community Court recognizes the value in offering holistic services that respond to a clients' needs, while not relying solely upon traditional policing to solve emerging community concerns. Instead, crisis response should be embedded within a holistic, integrated, health care and public health system with high quality, accessible and equitable services.[2] Community First links individuals to social and wellness services, while coordinating voluntary follow-up engagement built on relationships developed through consistent outreach. Specifically, Community First employs Community Navigators who partner with community-based organizations to engage individuals in social services, substance use treatment, and mental health services.

Community Navigators build trust by learning clients' stories, offering essentials like food, blankets, and access to bathroom facilities, and, over time, connecting them to long term support like housing, employment, and/or drug treatment through the program's partnerships with Breaking Ground and Fountain House. The Navigators have become a staple in the Times Square community, building meaningful connections with individuals frequenting Times Square and developing credibility with local businesses, community-based organizations, and other Times Square entities.

This credibility has allowed participants to successfully access supportive services and other opportunities. Often, the largest barriers community members face is the lack of knowledge of the systemic landscape and the prerequisites required to formally enroll in programming or receive services, and the inability of the system to meet growing demands. Navigators also connect individuals to Midtown Community Court's other programs and clinical services, as needed. "*This work is extremely important to me as someone with lived experience with substance use and justice involvement*," one Community Navigator wrote. "*My past allows me to form a deep connection to my clients and have a glimpse into some of the barriers they may be facing that other outreach workers may not understand… This work helps to remind me of the dark place where I was, while also advocating for the respect and dignity of those who are experiencing hard times."*

From July 2021 to December 2022, the Community Navigators have reached more than 604 individuals residing in or frequenting the Times Square area. Early data demonstrates that individuals are willing to continuously engage with Navigators, and over time begin to address their more substantive needs. The Community First team has over 1,628 interactions with community members, providing support to individuals working towards a range of meaningful outcomes. This data demonstrates that time spent building trusting relationships through consistent outreach is a key first step to addressing clients' more substantive needs, which ultimately must be met for a successful transition off the street. This consistent outreach of Community Navigators is showing promising initial results, and we hope it will develop into a model that can be replicated throughout the five boroughs to support individuals experiencing homelessness and housing insecurity.

Court-Based Solution; Misdemeanor Mental Health Court

The Center is committed to holistically serving people with mental illness, substance use issues, and co-occurring disorders. Founded as the independent research and development arm of the New York State Unified Court System, the Center has a long history of working with system actors to improve justice within and beyond the confines of the courtroom.

The Office of Court Administration (OCA) launched the Center's Midtown Misdemeanor Mental Health Court (MMHC). Misdemeanor Mental Health Court is a specialized court targeting people charged with misdemeanors who the court parties—judges, defense, and/or prosecutors—identify as having mental health challenges. The specialized court part provides meaningful and individualized responses to the myriad of issues that people living with serious mental illness and co-occurring disorders face, simultaneously addressing their treatment needs and the public safety concerns of the community. The MMHC takes on the most complex

misdemeanors where participants have high needs, extensive histories with the system, and are facing multiple open cases that bring them into the MMHC. Thus, the level of engagement is different than a typical misdemeanor alternative to incarceration.

Over the past year of building out the MMHC, Midtown staff have identified best practices that allow the Center to effectively engage and stabilize clients. The Center's rapid engagement model is the hallmark of our success. From the second the clients walk into the courtroom and throughout their case, they are greeted by Midtown staff who explain the MMHC court process, connect them to their attorneys, and provide a supportive presence while they wait for their case to be called. When clients meet with staff for programming and counseling sessions, they are offered food, clothing, and cell phones to address their most immediate needs.

The Center's highly individualized approach responds directly to client needs and can include in-house mental health counseling, case management, harm reduction services, linkage to benefits, and referrals to longer term care. Following a clinical assessment conducted by a Midtown Community Court Social Worker, the Midtown clinic team, defense, assistant district attorney, and the court attorney case conference to discuss treatment and mandate recommendations, provide client updates, and discuss case dispositions. These weekly case conferences have successfully built trust among the legal stakeholders and allow for rapid case resolutions; 33-44 days on average. Faster cases result in savings to the criminal legal system and allow participants to move forward with their lives without the burden of a court case.

Upon successful completion of the program, the judge presents the defendant with a certificate of completion. Graduates get a round of applause from Midtown staff, the attorneys, and everyone in the courtroom. Clients have reported that this affirmation, the engagement with staff, and the services offered make them feel seen and heard, reduces their anxiety and makes the court process feel positive and restorative. Clients have thanked staff and the Judge for taking the time to listen to them, acknowledging their challenges and concerns, and most importantly, their successes.

The success of MMHC is best exemplified by the story of Lenny. Lenny is a 33 year-old male with a diagnosis of Schizophrenia. He was living in supportive housing, engaged in psychiatric care, and proudly sober from alcohol for several years until he was devastated by the sudden death of his mother, his primary support. Lenny started drinking, went off his medications, and left his housing. He quickly decompensated and was subsequently arrested. He showed up at Midtown disheveled, disorganized, and very depressed. The Midtown team was able to get him back into his apartment and reconnect him with mental health care quickly and provide the support he needed through ongoing outreach and programming. His legal case was quickly resolved and he continued to meet with his social worker for voluntary sessions while he acclimated to being back in the community. Lenny is one of many clients who came through MMHC as a "defendant" and left feeling connected and respected with new resources and a positive experience with the justice system.

Since launching the MMHC, the Center has identified several common themes among the clients referred to us. Frequently, clients are arrested in a time of crisis when a destabilizing event results in the deterioration of their mental health or exacerbates their mental illness.

MMHC intervenes at that critical moment to identify and address the destabilizing factors in clients' lives to prevent further involvement in the criminal justice system.

Conclusion

Community First and the Misdemeanor Mental Health Court demonstrate strong coordination between the justice system, non-profits, business districts, and city agencies to respond to the needs of unsheltered New Yorkers suffering from mental illness and/or substance use disorders. The Center stands ready to continue implementing proven programming which connects individuals to the services they deserve, working with Council Members to forge creative solutions and adaptations. The Center thanks the City Council for its long-standing partnership. We are happy to answer any questions you may have.

Notes

[1]Bryan, C. & Harris, T. (2022). New York Daily News. *Better Solutions for those with mental illness.* Available at: https://www.nydailynews.com/opinion/ny-oped-long-term-needs-of-those-with-mental-illness-20221222-y5zh3fl2lbfilmhmmbothxk4ze-story.html.

[2]Fountain House, Center for Justice Innovation, The W. Haywood Burns Institute, the Technical Assistance Collaborative (TAC), the Mental Health Strategic Impact Initiative (S2i), the Ford Foundation. (2021). *From Harm to Health.* Available at: https://fountainhouse.org/reports/from-harm-to-health.

[3]Center for Justice Innovation. (2020). *Shrinking the Footprint of Police: Six Ideas for Enhancing Safety.* New York, NY. Available at: https://www.courtinnovation.org/publications/alternatives-to-police

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February 6, 2023

New York City Council Joint Hearing - Committee on Mental Health, Disabilities and Addiction, Committee on Hospitals, Committee on Fire and Emergency Management & Committee on Public Safety

Re: Hearing Testimony

Oversight – Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan.

Good afternoon,

My name is Sharon McLennon-Wier, Ph.D., MSEd., CRC, LMHC and I am the Executive Director for the Center for independence of the Disabled, New York (CIDNY). CIDNY's mission is to ensure full integration, independence, and equal opportunity for all people with disabilities by removing barriers to the social, economic, cultural, and civic life of the community. CIDNY represents all people with disabilities, including people with physical, mental, medical, emotional, behavioral, sensory, developmental, intellectual, and learning Disabilities.

CIDNY is testifying today before the City Council Committee on Mental health, Disabilities and Addiction to share our concerns regarding Mental Health Involuntary Removals, and specifically regarding Mayor Adams's recently announced plan on this issue which permits police officers to forcibly remove, detain and transfer to a hospital people who merely "appear" to have a mental illness and to be unable to meet their basic needs.

CIDNY shares the concerns voiced by other advocacy groups, and by the attorneys who have filed a lawsuit against the implementation of this plan.

While CIDNY recognizes that efforts need to be made to assist people experiencing mental illness, to address homelessness, and to ensure public safety in New York City, it is CIDNY's position that the plan as set forth by Mayor Adams represents a major violation of the protected rights of people with disabilities. This plan is in clear violation of the US constitution and civil rights laws, including the Americans with Disabilities Act of 1990 and the Americans with Disabilities Amendments Act of 2008. It is also dangerous, and an affront to the dignity of people with disabilities.

CIDNY further believes that the plan proposed by Mayor Adams to bring the people who are involuntarily removed from city streets to hospitals for psychiatric evaluations is not well thought

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out and would be impossible to implement. It is well known that there are not enough hospital beds to meet the need for additional beds this plan would create, and the number of new beds the mayor has indicated would be set aside for this plan is woefully insufficient. We have heard from various doctors who work at city emergency rooms who have publicly stated that that their hospitals and clinics do not have the capacity to implement this plan.

CIDNY also disagrees with the plan to have police officers from the NYPD as being the front-line responders to address the needs of people with perceived or actual mental disabilities. CIDNY is advocating for New York City to instead implement a system to have trained mental health professionals and peer mentors with mental health experience to respond and intervene with people who need assistance in the community. We call for training in the use of culturally competent psychological interventions, procedures, and therapies. Police officers are inadequately trained in mental health interventions, and the use of the policy as first responders in these situations is dangerous, and results in severe harm and long-lasting trauma to people with disabilities.

Instead of moving forward with the plan proposed by Mayor Adams, CIDNY is advocating for New York City to create a comprehensive plan to address the needs of people experiencing mental health issues, which incorporates the need for supportive and affordable housing, culturally competent psychological interventions, procedures, and therapies, and mental health supportive services. In addition, we call for the need for more trained clinicians to enter the field of psychological wellness. These new clinicians must adopt the principles which consists of culturally competent psychological interventions, procedures, therapies and mental health justice and reform for people of color living in New York City. It should not be a social class privilege to receive comprehensive mental healthcare. Mental healthcare is a right and not a privilege!

Thank you,

Sharon McLennon Wier, Ph.D., MSEd., CRC, LMHC

Executive Director

Center for Independence of the Disabled, NY

Testimony before the Joint New York City Council Hearing with the Committee on Mental Health, Disabilities, and Addition; Committee on Hospitals; Committee on Fire and Emergency Management; and Committee on Public Safety
February 6, 2023

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

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

www.communityaccess.org

Thank you to Chair Lee, Chair Hanks, Chair Ariola, Chair Narcisse, and all members of these committees for convening this important hearing. I appreciate the opportunity to testify on behalf of Community Access.

As the CEO of Community Access, I lead an organization that has long been at the forefront of efforts to transform our public mental health system into one where the voices of people living with mental health concerns are centered and play a vital role in the design, delivery, and evaluation of services.

Community Access is one of the leading providers of supportive housing in New York City, and we are the originators of an integrated housing model, which has become a best practice nationally: affordable and supportive housing where families reside alongside people living with mental health concerns. Our 350-person strong staff works daily to support thousands of New Yorkers living with mental health concerns through supportive housing, mobile treatment teams, job training, supported education, advocacy, crisis respite, and other healing-focused services. Community Access is also proud to be a founding member of the Correct Crisis Intervention Today in NYC Coalition (CCITNYC)[1], which is committed to transforming the City's mental health crisis response.

The Mayor's recently announced plans to involuntarily remove individuals who appear to be unhoused and a danger to themselves or others, and subsequently transport them to Emergency Departments for evaluation, is a flawed and potentially harmful response to a crisis that demands empathy and compassion, as well as a thorough examination of how our mental health system is failing those who need it most.

Increasing involuntary removals presents a host of potential harms to people living on the streets or subways – ranging from physical injury to emotional trauma and loss of life at the hands of police. As a reminder, 19 people experiencing mental health crises have lost their lives during police encounters in the last seven years. Countless others have been tazed or arrested. A Community Access staff person who has been on the receiving end of a police interaction during a mental health crisis said to me, "If they don't shoot you, they taze you." She herself was tazed and ended up in jail with a criminal record as a result of an NYPD encounter during a mental health crisis. This will happen to more and more people if this plan goes ahead.

In addition to the real dangers this poses to people, the idea of involuntary transport, evaluation, and hospitalization as solutions to our city's increasing number of people unhoused and unsheltered – is, in and of itself, deeply flawed. People will likely be right back where they started in a few weeks at most. The measures that Mayor Adams is calling for will only serve to create more harm and trauma, pushing even further away those whose needs have not been met by the system we currently have.

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[1] https://www.ccitnyc.org/

I could not be more opposed to the Mayor's plan. The shift that our system of care needs to make is one where we understand the centrality of listening to the people we exist to serve and are able to offer a range of treatment options that include more than a prescription and a hospital bed.

We need more rights-based, person-centered services that are accessible when needed and available in the communities where people live. In addition to accelerated access to supportive housing, these include: development of more safe havens, support and connection centers, building out a system of residential crisis support programs such as Community Access' respite center, and investing in a range of out-patient services to alleviate long wait times when people seek help.

This month, Community Access celebrates the tenth anniversary of the opening of the first-of-its-kind peer-driven Crisis Respite Center in NYC. Such places are critical to the healing journey of individuals experiencing a mental health crisis. Guests at our respite center receive peer support, self-advocacy education, as well as one-on-one and group counseling and workshops geared towards individual recovery needs. While I am proud to reach this ten-year milestone, it is disheartening to realize that, after a decade, these centers are still a rarity in the city. In fact, the numbers of respite centers operating throughout the city are dwindling, dropping by half since 2019, with only 4 open today.[2] The City would be wise to invest further in these types of voluntary community-based supports.

In addition to respite, we need more access to urgent care. The City currently only has two support and connection centers and seven drop-in centers for unhoused New Yorkers. This is far from where the city needs to be given the amount of people who are in need of expedited treatment and support for their mental health. Such centers should be opened across all five boroughs, remain operating on a 24/7 basis, and be the primary sources of help for those needing mental health assistance.

None of these community-based initiatives will be possible without greater attention towards compensation for workers in the human service sector. Mayor Adams recently unveiled his "Working People's Agenda" in his State of the City address, which prioritizes the working class. Left out of his agenda, however, was an investment in the human services sector, which employs 80,000 people — predominantly women and workers of color — who are some of the lowest paid workers in New York City while also being essential to our safety net programs.[3] It is these individuals who are responsible for many of the programs and services I speak of today, and yet any efforts at shoring up our public mental health system will be for naught if we do not create a wage structure where providers can recruit and retain these critical staff. We are experiencing a workforce crisis marked by high levels of turnover and high vacancies as a direct result of decades of undervaluing and underfunding this essential work.

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[2] https://advocate.nyc.gov/reports/improving-new-york-citys-responses-mental-health-crisis-2022/
[3] https://www.justpayny.org/

I am proud of the work Community Access and other allied organizations have done to push the conversation about mental health service delivery in a direction that is more person-centered and rights-based. With thoughtful policy choices and investments, we can create a more just city that meets people's needs, protects them from harm, recognizes human dignity, and supports them to make informed decisions about their own health and wellness.

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

Testimony of Housing Works
Before
The New York City Council Committee on Mental Health, Disabilities, and Addiction jointly with the Committee on Hospitals, the Committee on Fire and Emergency Management and the Committee on Public Safety

Regarding
Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan
February 6, 2023

Thank you for the opportunity to testify today. My name is Anthony Feliciano, and I am the Vice President for Community Mobilization for Housing Works, a healing community that provides a range of integrated medical, behavioral health, housing, and support services for over 15,000 low-income New Yorkers annually, with a focus on the most vulnerable and underserved—those facing the challenges of poverty, homelessness, HIV, mental health issues, substance use disorder, other chronic conditions, and incarceration.

Housing Works urges the Council to exercise your oversight authority to reject Mayor Adams' proposals to scale up involuntary, law-enforcement driven responses to New Yorkers with unmet mental health needs who are struggling to survive on our streets and subways. The so-called "plan" or directive announced by the Mayor last November – which proposes to expand the use of "removals" of people experiencing homelessness in public places in order to mandate them to mental health care that simply does not exist – is no more than another attempt by this Administration to use force against our most vulnerable community members in order to obscure the City's failure to meet its obligation to provide safe, effective, evidence-based solutions. The Mayor's administration must make a major aim of transparency about how the Involuntary Removals directive is being implemented and the impact on communities and neighborhoods. The Mayor's office should make public the details of how many more New Yorkers are being involuntarily detained, on what grounds, how long they are being kept in hospitals, and what kind of care and supports they receive during and at discharge. The Mayor's office should also make transparent the amount of NYPD time and resources that are being dedicated to this directive.

We at Housing Works are well aware that the City faces dual crises of untreated mental health needs and homelessness, both of which disproportionately effect low-income Black, Indigenous and people of color (BIPOC) NYC communities, and we strongly agree with the Mayor that the City has both a legal and a moral obligation to assist homeless New Yorkers suffering from untreated severe mental illness who are unable to meet their basic needs. But the Mayor's plan skips over the issues of a seriously underfunded public mental health system and almost complete lack of safe and appropriate housing placements for people with serious mental illness. It is meaningless and even cruel to harass and involuntarily remove people in an attempt to force them into a system of care that lacks the capacity to serve them. In addition, due to this increased involvement of police in mental health episodes, much of the provision of mental health care has now fallen to our carceral system.

At Housing Works, we know from regular experience how difficult or impossible it is to access care for serious mental illness. We are unable to access desperately needed mental health even for residents of our supportive housing programs. Indeed, a significant challenge facing Housing Works and other supportive housing providers are the unmet needs of residents who experience significant

mental health crises, often combined with substance use disorder. We provide over 700 units of supportive housing for the most vulnerable New Yorkers, including many residents people dealing with co-occurring mental health and substance use issues. While the overwhelming majority of residents manage these and other issues through behavioral health care provided by Housing Works or other community-based providers, not infrequently will a resident experience a crisis that necessitates transfer by EMS to the hospital. Invariably, these residents are released within a few hours, with no outpatient treatment plan. In one extreme case last week, Housing Works called emergency services four times over the course of three days for a resident experiencing psychotic episodes. Each time he was released back to us without any intervention, to the frustration not just of Housing Works but also the NYPD and EMS. Supportive housing is a compassionate and effective intervention, but without access to inpatient and outpatient mental health and substance use disorder treatment, untreated residents pose threats to others in a supportive housing environment that can eventually lead to their eviction – the worst possible outcome for the resident and the community.

We support the proposed Council initiative to mandate that the Mayor's Office of Community Mental Health to create an online services portal and guide to facilitate access to available services. This must be a funded mandate and a review of the shortage of mental health providers is necessary, in which many people of color and people who speak another language other than English struggle to find a therapist or other supports who shares their cultural background.

We oppose Council's proposed bill to require police officers to receive training on recognizing and appropriately interacting with individuals with an autism spectrum disorder. The conversation about training misses the larger culture of policing that sees lethal force as the ultimate tool to suppress crime and people they perceive a threat. The NYPD has a track record of being violent and deadly when responding to people experiencing or perceived to be experiencing a mental health crisis and abusing New Yorkers experiencing homelessness. As the NYPD killings of Iman Morales (2008), Mohamed Bah (2012), Saheed Vassell (2018), Deborah Danner (2016), Kawaski Trawick (2019) and too many others demonstrate, deploying NYPD Officers to address mental illness or homelessness puts more New Yorkers at increased risk of harm, violence and traumatization. In the last five years, there have been over 2,500 complaints against NYPD officers who forced people into psychiatric emergency rooms. [1] We cannot police our way out of the city's homelessness and mental health crisis. New Yorkers need a public health-based and community-driven approach to addressing individuals struggling with mental health and people experiencing homelessness that puts public health workers and peers at the forefront of engagement and expands voluntary mental health care, services, and support.

We also call on the Council to demand decisive action to promote the housing and services required to meet the needs of the many sheltered and unsheltered people experiencing homelessness who are coping with untreated or undertreated chronic medical and/or behavioral health issues. We must stop treating mental illness and substance use disorder among low-income New Yorkers as criminal justice rather than public health issues and instead adopt harm reduction approaches that provide every New Yorker with the safe, stable housing necessary to engage in behavioral health care, including private rooms for those struggling with mental health issues.

[1] https://www1.nyc.gov/assets/doi/reports/pdf/2019/Jun/19BiasRpt_62619.pdf

Recognizing the urgent needs of people experiencing homelessness on the streets or subways, Mayor Adams announced last May that over 1,000 new stabilization and safe-haven beds would be brought online within a year. Only a fraction of those beds has been added. In contrast, subway and encampment sweeps have continued unabated, and now the Mayor seeks changes to NYS's mental health laws to expand the power to involuntarily commit people experiencing homelessness and erode the confidentiality of their medical information. Coercive mental health treatment has not proven to have better outcomes than voluntary treatment. It is disproportionately applied to Black, Latinx, immigrants, LGBTQI people, and other communities of color who are often over-diagnosed and under-served. There are exemplary voluntary mental health programs that engage people with serious mental illness that should be expanded and invested in, including recovery-based mental health programs, respite centers, peer supports, clubhouses, harm-reduction programs, and other trauma-informed culturally and linguistically appropriate care that is accessible to Black, Latinx and other New Yorkers of color.

It is time for the Mayor to match rhetoric about compassionate care with actions that do not subjugate the needs of our most vulnerable citizens to largely unfounded fears regarding public safety and the demands of more politically influential constituencies. Despite his rhetoric of care and compassion, it is deeply alarming that the Mayor is cutting millions from the budgets of the Department of Health and Mental Hygiene, the Department of Social Services, the Department of Homeless Services, and the Department of Housing and Community Development. These agencies are already challenged to meet the needs of New Yorkers, and budget and staffing cuts will mean New Yorkers have even fewer resources.

Housing Works has worked with the Department of Homeless Services for over two and a half years on plans to open an innovative new model for addressing street homelessness that would combine street outreach, a drop-in center, and a stabilization hotel with private rooms and onsite medical and behavioral health care – all delivered employing an evidence-based low-threshold harm reduction approach that has been proven to enable persons to leave the streets, establish stability, and connect to needed care. A year ago, we had secured a hotel closed by COVID in a high-need Manhattan neighborhood, made the necessary alterations, and were two weeks away from opening a facility that would have provided 100 desperately needed stabilization beds when Mayor Adams pulled the plug on the project at the request of the Hotel Trades Council, an ally and supporter of his mayoral campaign. Other safe-haven and stabilization facilities have been likewise abandoned in the face of opposition from those with the Mayor's ear.

This must stop. We are facing an emergency, lives are at stake, and New York is simply better than this. We continue to work with DHS to secure another site, but it is time to prioritize community-based services and innovative models over politics.

New York City and the state have been left with a fragmented care system that fails many of its residents, ultimately filling up institutions with patients needing psychiatric and behavioral health care. Today we find ourselves in a situation where New York State's acute care hospitals (Article 28 authorized Diagnostic and Treatment Centers) provide the largest share of inpatient psychiatric services. Just under a hundred New York State acute care hospitals have inpatient psych program beds. Of the total available psych beds in the mental health-care system, New York State's psychiatric hospitals represent just under 30% of the state's inpatient psych capacity.[2] And the New

[2] https://profiles.health.ny.gov/hospital/bed_type/Psychiatric+Beds

York City Health + Hospitals System (NYC H+H), our largest public safety net hospital system, holds the lion's share of certified inpatient psych capacity in the city. We know how important understanding the mental health care delivery system is to recognize how woefully under-bedded the state is already in terms of inpatient psych capacity. Still, the ongoing need for beds, overall psych beds in New York has declined since the implementation of the Berger Commission (aka Hospital Closing Commission) and restructuring recommendations. Due to this, we know the state primarily regulates the distribution and planning of beds. Therefore, the city can continue calling on the state for more beds, but its attention or best use of its responsibilities should:

- Support existing evidence and promising housing, social service, and public health models to address socioeconomic stressors that worsen the mental well-being of all New Yorkers, especially marginalized communities.
- Ensure equitable review when deciding needs and where to place psych beds. This assessment must not occur in a vacuum with the State Department of Health. Community input and leadership are critical and necessary.
- Stress that our voluntary (private) hospitals and academic medical centers take their fair share of expanding psych beds because our public hospitals have disproportionately provided inpatient behavioral care.

In conclusion, Housing Works calls on the Council and the Administration to continue to be bold in addressing NYC's unprecedented homeless and behavioral health crises, through the rapid scale-up of evidence-based policies and practices. We must stop criminalizing and harassing people experiencing homelessness who opt for survival in public rather than entering frightening shelters. We urgently need new approaches and a new vision for what is acceptable.

Thank you for your time. Please don't hesitate to contact me, ***Anthony Feliciano***, Housing Works Vice President for Community Mobilization, with questions or additional information. I can be reached at a.feliciano@housingworks.org or 646-325-5317.

Committee on Mental Health, Disabilities and Addiction
Jointly with the Committee on Hospitals, the Committee on Fire and Emergency Management and the Committee on Public Safety

Mayor Adams' Directive Regarding Mental Health Involuntary Removals
February 6, 2023

Testimony submitted to the New York City Council by the Drug Policy Alliance

The Drug Policy Alliance (DPA) appreciates the opportunity to submit testimony to the New York City Council on the issue of Mayor Adams' directive regarding the involuntary removal of people perceived to have a mental illness.

DPA is the leading organization in the U.S. promoting alternatives to the War on Drugs. We envision a just society in which the use and regulation of drugs are grounded in science, compassion, health, and human rights; in which people are no longer punished for what they put into their own bodies; and in which the fears, prejudices, and punitive prohibitions of today are no more.

The Drug Policy Alliance opposes Mayor Adams' directive, which goes far beyond anything related to mental health and mobilizes the NYPD to sweep up essentially anyone who is experiencing street homelessness and disappear them. Prioritizing policing at the expense of investing in a public health infrastructure undermines public health, and we specifically wish to highlight the particular ways this directive will punish and perpetuate stigma against people who use drugs.

Police are not health responders

People who use drugs, including people struggling with substance use, are significantly represented among people with actual or perceived mental health needs and people who are unhoused. A directive that relies on police – not mental health experts – to make cursory judgments about people's mental state and health needs is likely to rest on stigmatizing beliefs about people struggling with substance use and replicate the punishment and marginalization that often contributes to mental health and housing instability.

Additionally, the NYPD has a terrible record of responding to people experiencing, or perceived to be experiencing, a mental health crisis. Despite the department's claims about the efficacy of de-escalation training police officers receive, the NYPD killings of Iman Morales (2008), Mohamed Bah

(2012), Saheed Vassell (2018), Deborah Danner (2016), Kawaski Trawick (2019) and so many others, highlight not only the insufficiency of de-escalation training as a substitute for actual health care providers but reinforce the immovable function of the police as frontline enforcers of the criminal legal system, designed for punishment.

This pattern of punishment instead of care further extends to the NYPD's treatment of unhoused New Yorkers. NYPD units routinely target unhoused New Yorkers, disrupting and displacing them, destroying their belongings, and sometimes inflicting physical harm to their bodies in the process.[1] The assertion that the same department directed to punish unhoused people can be deployed to provide care is a callous dismissal of the compounding and weathering toll that police encounters have on people.[2] Further, this type of antagonistic police contact can exacerbate the issues people are grappling with, which the Mayor claims to be addressing through this directive. Criminalizing people for visible poverty is not care and there is nothing in the Mayor's directive to suggest a deviation from these practices. Instead, under this directive, people who are among the most criminalized are at risk of being re-traumatized by more police engagement and a black hole of involuntary commitment.

Forced treatment is harmful

The Mayor's directive attempts to recast systemic failings as a lack of individual agency. Reducing the problem to individuals not seeking care minimizes the barriers people face in accessing voluntary treatment and care. Our voluntary support systems are significantly limited on the basis of cost, cultural competency, capacity, and insurance, causing many people who are voluntarily seeking care to be shut out. This is particularly true for people with co-occurring health needs, including substance use disorder. Decades of War on Drugs policies have created health care environments that are unwelcoming, hostile or punitive to people who use drugs, leading to negative treatment experiences and reinforcing their hesitation in seeking further treatment or care. These experiences are compounded by police interactions, making forced treatment mandated through civil commitment more frightening than helpful.

Each step of the Mayor's directive is harmful. Transporting people to hospitals against their will is traumatizing and strips individuals of their dignity and agency. For the many people who will be swept up through this directive who have a substance use disorder, being forcibly hospitalized can lead to painful and sometimes life-threatening withdrawal symptoms and place them at increased risk of overdose death.

Forced treatment is criminalization by another name, and like criminalization it is not effective to address root causes of instability and unwellness. Further, forced or coercive treatment is

[1] City Limits, The NYPD Now Decides What Homeless Encampments Get Swept, September 2022.
[2] Vera Institute, The Social Costs of Policing, November 2022.

disproportionately applied to Black, Latinx, immigrants, LGBTQI people and other communities of color who are often over-diagnosed and under-served by our health care systems.

The mayor's directive will only give the same results we've already received: long-term psychiatric incarceration with no pathway to wellness.

There are exemplary voluntary health care programs that should be expanded and invested in, including harm-reduction programs and other trauma informed and culturally appropriate care that is accessible to Black, Latinx and other New Yorkers who experience marginalization. One such program, run by OnPoint NYC, includes an overdose prevention center, and is specifically designed to provide wrap-around care for people who use drugs.[3]

Policing undermines public health

There is growing agreement among the public and policymakers that substance use is a matter of public health. However, there remains a lesser appreciation for the ways that heavy investments in policing undermine public health. As Governor Hochul works to expand the national 9-8-8 crisis hotline[4], Mayor Adams continues to invest in police as first responders, causing confusion and hindering efforts to build a non-police response infrastructure.

Despite his rhetoric of care and compassion, Mayor Adams continues to expand the role of the NYPD while simultaneously cutting millions from the budgets of the Department of Health and Mental Hygiene, the Department of Social Services, the Department of Homeless Services and the Department of Housing and Community Development. Specifically for people struggling with substance use, we also have not seen adequate investments in community-based low-threshold harm reduction and health programs, such as low-threshold housing, medication assisted treatment, and wrap around services for mind and body care. Cuts to these services – which are already struggling to meet the needs of New Yorkers seeking support – further inhibits a public health infrastructure and creates the conditions that destabilize people's lives and contribute to health issues.

Efforts to address public health must be grounded in evidence-based approaches. The lack of transparency around the Mayor's involuntary removals directive is extremely concerning. The Mayor's office should make public the details of how many more New Yorkers are being involuntarily detained, on what grounds, how long they are being kept in hospitals, what kind of care they are receiving, and what supports they received at discharge. The Mayor's office should also make transparent the amount of NYPD time and resources that are being dedicated to this directive, especially as non-police services are cut.

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[3] JAMA Network, First 2 Months of Operation at First Publicly Recognized Overdose Prevention Centers in US, July 2022.
[4] SAMHSA, From Crisis to Care: Building from 988 and Beyond for Better Mental Health Outcomes, November 2022

Solutions

New Yorkers need a public health-based approach to addressing substance use, mental health and homelessness that puts public health workers and peers at the forefront of engagement and expands voluntary health care, services, and supports. This includes more low-barrier, harm reduction and community-based models of supporting people who use drugs or who experience substance use disorder without the punitive layer of incarceration that exacerbates risk factors for overdose and death. Beyond health care, we need more supportive housing and a robust infrastructure of staffing and resources to get New Yorkers the support they need when they need it.

We are calling on the City Council to prioritize funding for actual public health solutions and oppose the mayor's directive.

For questions or more information, please contact Toni Smith-Thompson, New York State Director, at tsmith@drugpolicy.org, 212.613.8060.

ICL Testimony; *New York City Council's Committee on Mental Health, jointly with the Committee on Disabilities & Addiction, Committee on Public Safety, Committee on Hospitals & Committee on Fire and Emergency Management*
Monday, February 6, 2023 - 10 AM - Council Chambers, City Hall
Oversight - Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan

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Good morning, Chair Lee, Chair Hanks, Chair Narcisse, Chair Ariola, and members of the Committee on Mental Health, Disabilities & Addiction, Public Safety, Hospitals, and Fire and Emergency Management.

Thank you for the opportunity to testify today. My name is Jody Rudin, and I am the president and CEO of the Institute for Community Living.

ICL serves nearly 13,000 individuals a year who experience significant mental health challenges, substance use disorder, and intellectual and developmental disabilities. We take a person-centered, trauma-informed, whole-health approach to all our work, be it in our clinics, our shelters, and residences, or our community-based programs.

I applaud Mayor Adams and this Council for recognizing that we face a mental health crisis and committing to support the expansion of behavioral health and housing initiatives that are instrumental in helping people get better.

More than anything, I want to stress the importance of seeing the whole person in the work we do and of approaching the work with compassion and ensuring we center the voices and desires of the people we serve.

I'm here today to talk about the hardest to reach and hardest to treat individuals, though it is certainly true that many others lack access to mental and behavioral health services.

ICL's Continuum of Integrated whole health services – where individuals get mental health care, physical health care, access to food, shelter, work, case management, and more – are the programs that work best because they recognize the truths that people never have just one challenge and that much of what makes us feel better and be better happens outside a doctor's office.

Programs like Intensive Mobile Treatment (IMT), which the city just committed to expanding, are perfect examples of the kinds of programs that work in supporting those who have not been helped elsewhere. IMT is made up of comprehensive teams that meet all our client's needs; psychiatrists, nurses, housing specialists, case managers, peer specialists, and more. If

someone needs their blood pressure controlled, we help. If they are hungry, we feed them. If they need shoes, we buy them. IMT services have successfully placed 56% of homeless individuals into housing and participants have seen a 30% reduction in incarceration. -This is the kind of whole health approach we need to expand.

IMT teams meet clients wherever they may be. But that's just one model. At our East New York Health HUB, which combines the highest quality primary and mental health care and supports to address all the social determinants of health, people with the most significant traumas can access the full-day Personalized Recovery Oriented Services (PROS) program. It is the kind of intensive program many people need.

For the overwhelming majority of individuals, the community-based services I have described, and the many others that exist, that serve people in the least restrictive setting, work best.

But as someone who runs a behavioral health agency, worked in a homeless services nonprofit, and served as a Deputy Commissioner at DHS in charge of single adult homelessness, I know that a very, very small handful of individuals need more intense intervention. However, we must ensure that the Mayor's plan of involuntary hospitalization is done in a targeted way in partnership with the clinicians and case workers who know them. This is critically important to ensuring we do not create more trauma for people in crisis and set us back on the promise of de-institutionalization.

Of course, any program we embark upon will rely on human services staff to make it work. And this possibly presents the greatest challenge to our city and all plans to address the mental health crisis.

The ~~entire~~ human services workforce, particularly front line workers, is woefully underpaid. As a result, the turnover levels are astronomical and we struggle to hire staff. We can say we will expand all the programs we want, but if we can't hire the people to do the work, all our plans will simply only exist on paper.

I'm here to ask you today to finally do something to address the inadequate wages dictated by city contracts. We all know we need to increase access to mental health services; poor wages stand~~s~~ in the way. But this Council and the mayor can change that.

Thank you for giving me the opportunity to testify today.

Good morning,

Mr. or Madam Chair and members of the Committee, I am Lucina Clarke Executive Director and cofounder of My Time Inc. We have been providing educational, support, recreational and emotional wellness services to parents of a children with Autism and other Intellectual Disabilities for the past 15 years. I am here representing My Time Inc and the parents we serve.

I support this INT 273 presented by the Council Member Mercedes Narcisse who serves the 46 District where I live as well as serve the parents of a child with Autism. This bill provides a blueprint for training the New York City Police Department on being more aware of individuals with Autism and how to safely interact with an induvial on the Autism Spectrum. There are too many cases of our children with a disability being arrested because they may seem "normal" enough to comply with rules and regulations. However, most of them do not understand or comply to the norm. This training of identifying and recognizing these individuals is very important.

The CDC states, "Autism spectrum disorder (ASD) is a developmental disability caused by differences in the brain. Some people with ASD have a known difference, such as a genetic condition. Other causes are not yet known. Scientists believe there are multiple causes of ASD that act together to change the most common ways people develop. We still have much to learn about these causes and how they impact people with ASD."

People with ASD may behave, communicate, interact, and learn in ways that are different from most other people. There is often nothing about how they look that sets them apart from other people. The abilities of people with ASD can vary significantly. For example, some people with ASD may have advanced conversation skills whereas others may be nonverbal. Some people with ASD need a lot of help in their daily lives; others can work and live with little to no support. Some may seem like the "typical normal person" However, they may not respond to a command or directive given when in a situation that they cannot control.

Having trainings that teaches the officers how to recognize and respond to an individual with Autism is critical. This training will provide officers with practical knowledge about the individual and hopefully they can detect and be able to deescalate any unwanted or unwarranted behaviors that may cause the individual to react in an unsafe manner.

This training should be mandatory to all officers in the NYC Police Department and curriculum revised every 5 years to be updated with current diagnosis, modifications and language.

Thank you for listening to my remarks on behalf of the parents of My Time Inc.

Lucina Clarke

Executive Director and Cofounder

My Time Inc

lucina@mytimeinc.org

Hello and thank you for the opportunity to share the views of thousands of New Yorkers who are faced each day with major mental health, addiction and trauma related challenges.

My name is Luke Sikinyi and I am the Director of Public Policy of the New York Association of Psychiatric Rehabilitation Services (NYAPRS).
NYAPRS is a 41-year-old statewide partnership of people who use and/or provide community mental health services that have dedicated ourselves to improving culturally appropriate, public policies and social conditions for people with mental health, substance use and trauma-related challenges.

We do so by promoting approaches grounded in the belief that recovery is the expectation for all, no matter the severity of their current circumstances or challenges, and by providing proven recovery focused services including community-based housing, health care, rehabilitation and peer support.

This work is particularly important to us because our organization is mostly staffed by people in long term mental health recovery. I have experience both receiving and providing mental health services in New York City. I will be providing recommendations for proven approaches that have worked to engage the most distressed individuals, both in crisis and thereafter.

BACKGROUND
We all know the current level of unmet mental health, substance use, and basic living needs have created a longstanding public health crisis, one that too often has been conflated into a public safety measure.

So many of us live with enough fear, shame and stigma....adding violence to this equation is so hurtful, damaging and often another reason why people don't engage.

Rising rates of violence have shaken us all, but our community members should not be seen or scapegoated as its source. According to the U.S. Department of Health & Human Services, only 3%–5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are at least 10 times more likely to be victims of violent crime than the rest of the population.

Moreover, the risk of being killed during a police incident is 16-times greater for individuals with mental health challenges than the general public when approached or stopped by law enforcement.

While it was encouraging that the mayor does not want the city to ignore those struggling with homelessness and mental health challenges any longer, centering

his response on involuntarily sending people to hospitals will not address the root causes of this crisis.

THE ANSWERS

People lacking food, shelter, clothing should not be involuntary scooped off the streets by police but should be offered a broad array of compassionate community services.

Simply adding more hospital beds will not solve New York's mental health crisis and may well continue New York's record of failed discharges and recidivism, especially if they are involuntary.

Once admitted, it is essential that people leave with someone to walk with them into the community and provide up to a year of support: we call them peer bridgers. It is also essential that people are afforded a place to live that will accept, not exclude them because of active struggles with symptoms and/or addiction: we call those housing first beds. Finally, it's essential that people have a supportive place to go, often a clubhouse or peer recovery center. This will ensure that we are using hospital beds appropriately and not just as a place to send people away to with no improvement in their lives.

We have been encouraged by the unprecedented investment into the mental health system by Governor Hochul. Many of these investments focus on the social determinants which affect recovery, including housing, employment, education, and community services. There are many promising programs which both OMH and DOHMH are bringing online, but there was no mention of this in the mayor's directives back in November.

The focus on involuntary removals not only increases stigma for our community, but it also fails to educate the public about many wonderful programs which have proved more successful in helping people recover than any policies centered on coercion.

We have so many models, some decades old, some that should be brought online tomorrow, that New York City must embrace as the true solutions. Below is a short list of some of these models. I have included a list of many community based voluntary alternatives to the use of involuntary hospitalizations at the end of this testimony for your reference.

People You can Trust
Outreach and Engagement

- Safe Option Support (SOS) teams are one way. Another is
- INSET, a peer led outreach, engagement and support program created by NYAPRS and the Mental Health Association of Westchester that is showing an

80% rate of success with people who would otherwise be on a Kendra's Law court order.

People and Places to Turn to in A Crisis

- 988
- Peer and EMT first responders instead of police
    - Daniels Law: proposed legislation which would create local committees to plan and implement non police response teams for mental health and substance use crisis calls.
- Crisis stabilization
- Peer respite: homelike settings providing warm empathetic support in a crisis; contract that with traumatizing days in a local hospital ER.

Housing that Accepts not Excludes
Accessible Emergency and Permanent Housing

- Housing First and Safe Haven residential programs

Places to go

- Clubhouse programs that surround people with a community of hope, help and a return to dignity and employment

We ask the mayor to walk back this unnecessary focus on coercion and involuntary hospitalizations and instead focus on improving access to appropriate housing, voluntary mental health services, and humanizing those in the greatest need of compassion.

We look forward to working with the Adams Administration, DOHMH, and the Hochul Administration to expand and improve mental health, substance use, and street outreach services in New York City.

As the mayor said, we cannot continue to walk by our fellow New Yorkers in need. But we must not neglect our call to treat people with compassion and understanding in the hopes of a quick fix.

Fixing this system, which has lacked real investment for decades, will require serious commitment. We are here because of that commitment; we ask the Adams Administration to show that same commitment by putting forth policies which will help our community and not cause more harm.

We deserve the opportunity to recover with dignity.

Thank you.

NYS COMMUNITY BASED VOLUNTARY INNOVATIONS FOR AT-RISK INDIVIDUALS

RESIDENTIAL PROGRAMS

Crisis Respite – Intensive Crisis Residential Program: OMH program: "a safe place for the stabilization of psychiatric symptoms and a range of services from support to treatment services for children and adults. are intended to be located in the community and provide a home-like setting."

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

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

Pathways Housing First: a housing approach that prioritizes permanent housing for people experiencing homelessness and frequently serious mental illness and substance use issues. Supportive services including substance use counseling and treatment are part of the model, but abstinence or even engagement in services is not required. Research studies examining this model have shown that it dramatically reduces homelessness and is significantly more effective than traditional treatment and housing models

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

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

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

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

Parachute NYC: provides a non-threatening environment where people who are coming undone can take a break from their turbulent lives and think through their problems before they reach a crisis point. Many who shun hospitals and crisis stabilization units will voluntarily seek help at respite centers. Parachute NYC includes mobile treatment units and phone counseling in addition to the four brick-and- mortar respite centers.

NON-RESIDENTIAL PROGRAMS

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

INSET: a model of integrated peer and professional services provides rapid, intensive, flexible, and sustained interventions to help individuals who have experienced frequent periods of acute states of distress, frequent emergency room visits, hospitalizations, and criminal justice involvement and for whom prior programs of care and support have been ineffective. Mental Health Association of Westchester has found that participants, previously labeled "non-adherent," "resistant to treatment" or "in need of a higher level of care" and "mandated services," become voluntarily engaged and motivated to work toward recovery once offered peer connection, hope and opportunities to collaborate, share in decisions and exercise more control over their lives and their services and supports their treatment plans. The program has high rates of success, successfully engaging 80% of people who were either AOT eligible or AOT involved.

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

NYCDOMHM Intensive Mobile Treatment teams: provide intensive and continuous support and treatment to individuals right in their communities, where and when they need it. Clients have had recent and frequent contact with the mental health, criminal justice, and homeless services systems, recent behavior that is unsafe and escalating, and who were poorly served by traditional treatment models. IMT teams include mental health, substance use, and peer specialists who

provide support and treatment including medication and facilitate connections to housing and additional supportive services.

Pathway Home™: a community-based care transition/management intervention offering intensive, mobile, time-limited services to individuals transitioning from an institutional setting back to the community. CBC acts as a single point of referral to multidisciplinary teams at ten care management agencies (CMAs) in CBC's broader IPA network. These teams maintain small caseloads and offer flexible interventions where frequency, duration and intensity is tailored to match the individual's community needs and have the capacity to respond rapidly to crisis. The program employs a Critical Time Intervention (CTI) is a time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of transition. It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods.

Fountain House: Fountain House takes a public health approach to serious mental illness. We address both the health and social needs of our members through an integrated model that connects our physical clubhouse – where members are engaged in an innovative therapeutic community rooted in Social Practice, and take steps in reclaiming their agency and dignity – with access to clinical support, housing, and care management

Forensic Mobile Teams: The Westchester Forensic Mobile Team works directly with law enforcement in the field and courts seeking alternatives to incarceration (ATI), to provide immediate crisis response and/or transitional care services to people at risk of entering the criminal justice system due to under-addressed mental health, addiction, or social determinant of health issues.

Oversight Hearing– Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan

before the

Commitee on Mental Health, Disabilities and Addiction
jointly with the
Committee on Hospitals, the Committee on Fire and Emergency Management, and the Committee on Public Safety

on

Monday, February 2nd, 2023

Testimony By: Kimberly Blair, MPH

Director of Public Policy & Advocacy

National Alliance on Mental Illness of NYC (NAMI-NYC)

RE: NAMI-NYC Stands Against Mayor Adams' Inhumane Directive to Forcibly Remove and Involuntarily Hospitalize New Yorkers Experiencing Mental Illness and Homelessness

INTRODUCTION

Good Morning Chair Lee, Chair Narcisse, Chair Hanks, Chair Ariolai and Members of the Committee on Mental Health, Disabilities and Addiction, the Committee on Hospitals, the Committee on Fire and Emergency Management, and the Committee on Public Safety. Thank you for holding this space today to hear from community members living with mental health conditions, their loved ones, and the community-based organizations that strive to support both of these populations. My name is Kimberly Blair, and I am testifying on behalf of the National Alliance on Mental Illness of New York City (NAMI-NYC), where I serve as the organization's Director of Public Policy & Advocacy. On a personal level, I am also testifying today as a peer, or someone who lives with one or more mental health diagnoses.

NAMI-NYC is a grassroots mental health advocacy organization, and one of the largest affiliates of the National Alliance on Mental Illness. For 40 years, our organization has provided free, groundbreaking advocacy, education, and support services to individuals affected by mental illness and is the only organization in NYC to extend these services to their family members, caregivers, and friends, completely free of charge. Our organization extends services to family members, caregivers and friends, so that these individuals can serve as a strong support system for their loved ones living with mental health conditions.

One of the services we provide to loved ones is a Helpline, which operates Monday through Friday 10:00am to 6:00pm, offering resources, referrals and support to peers and family members, including at times, providing free information regarding assisted outpatient treatment, or AOT, and regarding supportive housing and shelter resources across the city. We mention these resources

to highlight our extensive experience and expertise working with people navigating through both mental health and housing challenges as well as their loved ones.

It is this extensive experience and expertise that led our organization to publish a public statement on November 29th against Mayor Adams' directive to inappropriately expand Kendra's Law to promote AOT as a first response intervention to the mental health and housing crisis affecting New York City.[1] It is also this background knowledge that brings us here today to give testimony before the joint committees denouncing the Mayor's directive again.

ARGUMENTS

I. Assisted Outpatient Treatment (AOT) is Not a Correct Public Health Response

AOT is intended as a **last resort mechanism**, not a mental health response. The City even explains on its website how Kendra's Law:

> "mandates mental health services for a small number of individuals who have difficulty engaging in rehabilitation and can pose a risk to themselves or others in the community. The order is granted in civil court. The New York City Assisted Outpatient Treatment program is responsible for the implementation of Kendra's Law in the five boroughs of New York City."[2]

The City's website then proceeds to detail the long list of criteria an individual must meet for AOT eligibility, including:

- "Be at least 18 years of age and
- Suffer from a mental illness and

[1] *NYC response to mayoral address on November 29*. NAMI-NYC. (2022, November 29). Retrieved February 8, 2023, from https://naminycmetro.org/involuntaryremoval/

[2] *Assisted outpatient treatment (AOT)*. NYC Health. (n.d.). Retrieved February 8, 2023, from https://www.nyc.gov/site/doh/health/health-topics/assisted-outpatient-treatment.page

- Be unlikely to survive in the community without supervision based on a clinical determination and
- Have a history of lack of compliance with treatment for mental illness which has led to:
    - Two hospitalizations for mental illness in the preceding three years or
    - One act of violence towards self or others, or threats of serious physical harm to self or others, within the preceding four years (time period may be extended in the event of current or recent hospitalizations) and
- Be unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community as a result of the individual's mental illness and
- Based on treatment history and current behavior, be in need of outpatient treatment to prevent a relapse or deterioration likely to result in serious harm to self or others and
- Likely benefit from Assisted Outpatient Treatment."[3]

The reason for this long list of eligibility criteria and narrow definition of Kendra's Law is to avoid misuse of AOT against community members with mental illness. Historically, people with serious mental illness (SMI) have been locked away in hospitals and other institutions to hide our growing mental health crisis from society—a crisis resulting from the under-resourcing of mental health care services and housing infrastructure in our communities. In essence, the long list of criteria is in place to prevent immoral and illegal tactics, such as the "Mental Health Involuntary Removals" directive proposed by the Administration, against our community members with mental illnesses.[4]

[3] *Id.*

[4] *Mental Health Involuntary Removals*. nyc.gov. (2022, November 28). Retrieved February 9, 2023, from https://www.nyc.gov/assets/home/downloads/pdf/press-releases/2022/Mental-Health-Involuntary-Removals.pdf

People living with SMI have a right to person-centered and recovery-oriented mental health care. Instead of using the least restrictive approach, we are defaulting to an extreme that takes away basic human rights. We need to meet people where they are, not forcibly remove them. We also need to allow mental health experts, such as clinicians and peer specialists, to make determinations as to what the best first-line intervention should be for the small subset of community members with SMI experiencing housing instability. The City has the power to provide onsite treatment, as well as treatment in homeless shelters or in providing adequate supportive housing, but has chosen not to.[5]

II. Police Officers are Inappropriate First Responders to NYC's Mental Health Crisis Calls

Additionally, New York City is in dire need of a true non-police response to mental health crises because even with training, the officers of the New York Police Department have consistently failed as first responders to mental health crisis calls. In fact, nineteen individuals since 2015 have been killed by the New York Police Department after officers responded to their mental health crisis calls.[6] Of these nineteen lives lost, sixteen individuals identified as Black or Brown. These failed attempts to respond to people facing mental health crises are due in large part to the fact that policing, by design, is a field intended to deal with public *safety* emergencies, not public health crises.[7] Therefore, there is no amount of Crisis Intervention Training or other type of training, as proposed by the Mayor, that could measure up to a mental health clinician or peer crisis

[5] Hicks, N. (2022, March 9). *Most city homeless shelters don't offer needed mental health services*. New York Post. Retrieved February 9, 2023, from https://nypost.com/2022/03/09/most-nyc-shelters-dont-offer-needed-mental-health-services-records/

[6] Community Access, Inc. (2022). *CCIT-NYC: In Remembrance*. Retrieved June 21, 2022, from https://www.communityaccess.org/ccit-nyc-in-remembrance.

[7] *Why doesn't CIT International promote the embedded co-responder model?* CIT International. (2021, July 6). Retrieved February 9, 2023, from https://www.citinternational.org/resources/Documents/Position%20Papers/CIT%20Int%20Embedded%20Co-response%20Position%20Paper.pdf

worker, who devote their whole careers to providing crisis intervention, de-escalation and prevention services.

Instead, under New York's current model, the police still respond to nearly 20% of mental health crisis calls dispatched to Behavioral Health Emergency Assistance Response Division, or B-HEARD.[8] These inappropriate, first-response interactions with the police have historically led to the over-incarceration and criminalization of people living with mental illness in our City and State. People in crisis therefore could easily never make it to the psychiatric hospital or the alternative crisis respite center that they need because they are met with handcuffs, incarceration, or worse. We know through our work with program participants and with the Treatment Not Jail Coalition that many individuals have had their mental condition exacerbate and deteriorate after a police encounter or while waiting for a psychiatric evaluation in our city's jails. One of our Advocacy Ambassadors and NAMI-NYC community members relayed to us how officers took her service animal away from her during a wellness check in the middle of her suffering from a post-traumatic stress disorder episode. Other community members tell us how police encounters have caused their family member with a mental health diagnosis to stop seeking care or fall off from their recovery journey after officers forcibly restrained and transported their loved ones to the hospital.

Such is the reason why NAMI-NYC stands against involuntary hospitalization as a first response to New Yorkers who are unhoused and experiencing mental health crises. It is also the reason why our organization serves as a plaintiff in *Justin Baerga, et al. v. City of New York, et al.*,[9] a case challenging the NYPD's inhumane and detrimental "Emotionally Disturbed Person

[8] The City of New York. (2021, December 15). *Transforming NYC's response to Mental Health Emergencies. FIRST SIX MONTHS OF OPERATION.* B-HEARD. Retrieved June 20, 2022, from https://mentalhealth.cityofnewyork.us/wp-content/uploads/2021/12/FINAL-DATA-BRIEF-B-HEARD-FIRST-SIX-MONTHS-OF-OPERATIONS-12.15.21-1.pdf.

[9] Baerga, et al. v. City of New York, et al., Case 1:21-cv-05762-AJN (2021): First Amended Class Action Complaint.

(EDP)" policy towards our community members. It is also the reason why we believe that the city's current B-HEARD program needs to be amended and re-envisioned to move towards Correct Crisis Intervention Today of NYC (CCIT-NYC)'s evidence-based, peer-led response proposal. The model works by centering peer crisis workers and independent Emergency Medical Technicians (EMTs) as first responders to mental health crisis calls.[10] The City should prioritize adjusting the B-HEARD model to adopt this peer-centered approach, especially in light of the new, nationwide 988-crisis number, which will took effect July 16, 2022.[11]

III. Investments in Community Care, Not Coercion, is the True Solution

Furthermore, there is a fundamental misunderstanding about the intended impact of Kendra's Law or AOT on increasing mental health care access. Even when mandated or involuntary care is needed, which is in a small percentage of cases,[12,13] our current mental health care system remains under-resourced and ill-prepared to respond to emergency situations. We know from the results of our most recent Psychiatric ER Survey that 50 in-patient hospital beds are not enough. People in crisis are experiencing long wait times for evaluations and admissions—sometimes in waiting rooms or on gurneys in hallways. Through the qualitative data collected from our survey, our organization learned that some of one of our community members specifically was left "on a gurney in the hallway of the psych ER surrounded by other patients, being watched by security and with fluorescent lights on for 3 nights and 2 days..."

Anecdotally, NAMI-NYC also knows many of community members who have sought emergency services in their neighborhoods, only for ambulances to have to transfer to other

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[10] *Our proposal*. CCIT-NYC. (n.d.). Retrieved February 8, 2023, from https://www.ccitnyc.org/ourproposal

[11] Vibrant Emotional Health. (2022). *The Lifeline and 988*. NATIONAL SUICIDE PREVENTION LIFELINE. Retrieved June 21, 2022, from https://suicidepreventionlifeline.org/current-events/the-lifeline-and-988/.

[12] *Assisted outpatient treatment (AOT)*. NYC Health. (n.d.). Retrieved February 8, 2023, from https://www.nyc.gov/site/doh/health/health-topics/assisted-outpatient-treatment.page

[13] *Kendra's Law: Results from New York's first ten years with Assisted Outpatient treatment*. Treatment Advocacy Center. (n.d.). Retrieved February 8, 2023, from https://www.treatmentadvocacycenter.org/component/content/article/41

hospitals in Westchester County, Long Island, or in another borough away from their family and community supports due to long wait times, bed shortages, or lack of personnel available to tend to their crisis. For example, one family respondent to our ER Survey stated, "Round trip commute for us was 5 hours. (2 1/2 hour trip each way!)." Our organization wants City Council to remember these common experiences when it finalizes this fiscal year's budget -- what our community members need is a peer-led, non-police response and more investments in a community care model, such as in more BIPOC providers, more culturally-competency trainings and more supportive housing with wraparound services, in order to appropriately respond to the needs of those in crisis and avert crises from happening in the first place.

While every mental health crisis is an emergency, not every crisis call warrants the response or services provided by inpatient hospital settings. Crisis respite centers and 24/7 walk-in mental health clinics are alternative settings to psychiatric emergency hospitals that have the capability to de-escalate and stabilize a number of mental health crises. While many of these crisis respite centers have the capability to respond to crisis calls, they often do not have the capacity due to limited financial support and resources from the city and/or state. For example, our colleagues at Community Access, Inc., operate a community-based crisis respite center, that centers peer crisis workers, provides a home-like environment, runs 24 hours/7 days a week and produces stellar outcomes in stabilizing individuals in crisis and connecting them to a continuum of aftercare resources in their neighborhoods.[14] The State and City should rely on expanding access to these community-based models for New Yorkers with serious mental illness, rather than re-inventing the wheel or solely relying on hospitals, which are currently short-staffed and improperly over-utilized. Furthermore, investments in treatment adjacent services, such as the

[14] New York State Office of Governor Kathy Hochul. (2022, February 18). *Governor Hochul announces major investments to improve psychiatric support for those in crisis*. Governor Kathy Hochul. Retrieved June 19, 2022, from https://www.governor.ny.gov/news/governor-hochul-announces-major-investments-improve-psychiatric-support-those-crisis

psychoeducation classes and support groups offered to peers and family members at NAMI-NYC, are necessary to reinforce family and friend support systems that can reduce housing instability or emergency crisis needs among people living with SMI or other mental illnesses. Funding these services is imperative now more than ever as waitlists to access non-emergency mental health care services keep growing since the onset of the pandemic.

CONCLUSION

For all of these reasons, we hope you consider our testimony and commit to holding the Administration accountable in ensuring the dignity and humanity of people navigating through housing and mental health challenges. If the Administration or Council is open to meetings, NAMI-NYC and many of our partners are open for consultation on what are best practices to engage this population in order to promote voluntary participation and just access to care and community-based services that could lead to lifelong recovery.

Thank you for your time,

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New York City Council Public Hearing
Committee on Public Safety
Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan

Written Testimony of the New York City Bar Association
February 6, 2022

The New York City Bar Association (City Bar),[1] through its Civil Rights Committee, Disability Law Committee, Mental Health Law Committee, and Social Welfare Law Committee, urges Mayor Adams to pause implementation of the new directive on "mental health involuntary removals" (the "NYC Removal Directive").[2]

The NYC Removal Directive purports to clarify that the NYPD and other agencies are empowered to forcibly remove from public spaces people who appear to have a mental illness and to be unable to meet their basic needs to an extent that causes them harm. This vague and broad initiative raises significant legal issues that demand careful review to ensure the City's compliance with City, State, and Federal anti-discrimination laws, as well as State laws governing mental health treatment and the U.S. Constitution. Furthermore, as is evidenced by the numerous concerns raised by directly impacted individuals and groups advocating for people with mental illness, the NYC Removal Directive also presents serious policy concerns that deserve thoughtful consideration and would benefit from additional stakeholder input. We call on the City to pause its rushed implementation of the NYC Removal Directive and engage in a transparent and good faith dialogue with service providers, advocates, and directly impacted individuals to design interventions that are evidence-based, consistent with individuals' rights and autonomy, and do

[1] The mission of the New York City Bar Association, which was founded in 1870 and has over 23,000 members, is to equip and mobilize a diverse legal profession to practice with excellence, promote reform of the law, and uphold the rule of law and access to justice in support of a fair society and the public interest in our community, our nation, and throughout the world.

[2] On November 29, 2022, Mayor Adams delivered an "Address on the Mental Health Crisis in New York City" transcript available at: https://www.nyc.gov/office-of-the-mayor/news/871-22/transcript-mayor-eric-adams-delivers-address-mental-health-crisis-new-york-city-holds (all websites last visited February 2, 2023). The 5 page directive that was released with the announcement is captioned *Mental Health Involuntary Removals, as of 11/28/2022*, and is available at: https://www.nyc.gov/assets/home/downloads/pdf/press-releases/2022/Mental-Health-Involuntary-Removals.pdf. Following the announcement, the City has communicated the new policy to its police officers through a FINEST message dated December 6, 2022 (FINEST message). The FINEST message was posted on the docket in the *Baerga et al. v. NYC et al.*, 21-cv-05762 (SDNY) (PAC) litigation, ECF/Docket # 123-1.

About the Association
The mission of the New York City Bar Association, which was founded in 1870 and has over 23,000 members, is to equip and mobilize a diverse legal profession to practice with excellence, promote reform of the law, and uphold the rule of law and access to justice in support of a fair society and the public interest in our community, our nation, and throughout the world.

not violate (on their face or in their implementation) our anti-discrimination laws or the U.S. Constitution.

Below, we highlight our primary legal and policy concerns and reiterate fundamental principles—such as autonomy in decision-making and the "least restrictive alternative"—that we believe should undergird any future City initiative affecting people with mental health conditions.

First, the City's broad language in the NYC Removal Directive would allow removals that are not justified under the U.S. Constitution or State mental health law;

Second, the City's language announcing this initiative both reflects and will exacerbate bias against unhoused people and people with serious mental illness, in violation of anti-discrimination principles, and the NYC Removal Directives will disproportionately burden people of color; and

Third, this initiative directs resources into a failed strategy, at a time when the City has reduced investments in effective strategies that connect people to long term treatment and care.

I. The City's broad language would allow removals that are not justified under the U.S. Constitution or State law.

Summary

Under Mental Hygiene Law (MHL) sections 9.41 and 9.58, the City has the prerogative to remove individuals to a hospital involuntarily under certain circumstances. Indeed, public reporting indicates NYPD effectuated more than 1,000 such removals in 2022 before the issuance of the NYC Removal Directive.[3] This authority which, under section 9.41 is vested in peace officers and law enforcement officers, and under section 9.58 is additionally vested in physicians and certain mental health professionals, is constrained by the Constitution. The New York State Office of Mental Health ("OMH") guidance largely aligns with the caselaw around mental hygiene arrests under MHL § 9.41 with respect to both the probable cause standard and the requirement of an inability to meet basic needs such that a person presents a present risk of harm to self. The mayor's announcement and the accompanying NYC Removal Directive, however, do not.

Background Law and Policy

The Mental Hygiene Law ("MHL") provides authority for peace officers and law enforcement officers to take into custody for the purpose of a psychiatric evaluation those individuals who appear to be mentally ill and are conducting themselves in a manner which is

[3] Ethan Geringer-Sameth, "Police Have Removed Over 1,300 'Emotionally Disturbed People from Transit in 2022; Where Did They Go?" Gotham Gazette, Dec. 13, 2022, https://www.gothamgazette.com/city/11717-adams-nypd-subway-mental-illness-removals-hospitals.

likely to result in serious harm to self or others. MHL § 9.41.[4] Additionally, MHL § 9.58 provides that "a physician or qualified mental health professional who is a member of an approved mobile crisis outreach team shall have the power to remove" someone under the same circumstances.[5]

OMH Commissioner Ann Marie T. Sullivan and Chief Medical Officer Thomas Smith issued interpretive guidance in February 2022 (the "OMH Involuntary Removal Guidance") setting forth the circumstances under which courts have determined that the MHL permits "persons who appear to be mentally ill and who display an inability to meet basic living needs" to be mandated into emergency psychiatric assessments and emergency and involuntary inpatient psychiatric admissions.[6]

Constitutional Considerations

In discussing involuntary confinement, the United States Supreme Court has stated that "a State cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975). The Court added that "[m]ere

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[4] Like most of the provisions of Article 9 of the MHL relating to involuntary admission and treatment, MHL § 9.41 rests on the definitional construct of "danger" to self or others, permitting what is commonly referred to as a Mental Hygiene "arrest." Section 9.41 provides as follows:

> Any peace officer, when acting pursuant to his special duties, or police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department **may take into custody any person who appears to be mentally ill and is conducting himself in a manner which is likely to result in serious harm to himself or others. "Likelihood to result in serious harm" shall mean (1) substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or (2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.** Such officer may direct the removal of such person or remove him to any hospital specified in subdivision (a) of section 9.39 or, pending his examination or admission to any such hospital, temporarily detain any such person in another safe and comfortable place, in which event, such officer shall immediately notify the director of community services or, if there be none, the health officer of the city or county of such action.

N.Y. Mental Hyg. Law § 9.41 (emphasis added).

[5] N.Y. Mental Hyg. Law § 9.58 uses identical language ("any person who appears to be mentally ill and is conducting himself in a manner which is likely to result in serious harm to himself or others") and does not elaborate on the standard for likelihood for serious harm articulated in § 9.41. Though the NYC Removal Directive purports to authorize numerous agencies, including many that employ individuals covered by § 9.58, the City Bar is not aware of any specified guidance that has been provided by any of these agencies. The legal issues presented by the overbroad language of the NYC Removal Directive are not ameliorated depending on whether a peace office or mental health professional makes the determination. That said, arrests pursuant to § 9.41 present a special risk, since peace officers are not trained mental health professionals, are armed, and are authorized to use force in certain instances.

[6] *See* Interpretative Guidance for the Involuntary and Custodial Transportation of Individuals for Emergency Assessments and for Emergency and Involuntary Inpatient Psychiatric Admissions, Date: February 18, 2022, https://omh.ny.gov/omhweb/guidance/interpretative-guidance-involuntary-emergency-admissions.pdf. This document was issued by OMH in connection with Governor Hochul's and New York City Mayor Eric Adams' unveiling of their joint plan to remove people from the New York City subway system. *See* The Subway Safety Plan, https://www1.nyc.gov/assets/home/downloads/pdf/press-releases/2022/the-subway-safety-plan.pdf.

public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty." *Id.* At 575. In a Second Circuit case dealing with the seizure of a woman for a psychiatric evaluation, the Court held that evidence that the woman appeared irrational, annoyed, and very uncooperative was not sufficient to imply that she appeared dangerous and to establish probable cause for arrest. *Myers v. Patterson*, 819 F.3d 625, 632 (2d Cir. 2016).

Federal courts have long read constitutional guarantees of due process into the various provisions of MHL's Article 9 as they relate to involuntary retention and treatment. *See e.g. Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983). It is well settled that for involuntary removals under § 9.41 of the MHL, "courts apply the same concepts of probable cause and objective reasonableness as in criminal cases to determine whether the confinement is privileged because the plaintiff's behavior was likely to result in serious harm." *Greenaway v. County of Nassau*, 97 F. Supp. 3d 225, 233 (E.D.N.Y. 2015). In doing so, courts treat involuntary removals as "the functional equivalent of [] arrest[s]," *Disability Advocates., Inc. v. McMahon*, 279 F. Supp. 2d 158, 168-69 (N.D.N.Y. 2003), *aff'd,* 124 F. App'x 674 (2d Cir. 2005). It should be noted that no caselaw specifically assesses whether inability to meet basic needs rises to the level of probable cause to justify a mental hygiene arrest under MHL § 9.41.

Probable cause for an involuntary hospitalization under the mental hygiene laws—a so-called "mental health arrest"—only "exists if there are reasonable grounds for believing that the person seized is dangerous to herself or to others." *Guan v. City of New York*, 2020 WL 6365201, at *2 (S.D.N.Y. Oct. 29, 2020), *aff'd on other grounds*, 37 F.4th 797 (2d Cir. 2022) (internal citation and quotation omitted); *Anthony v. City of New York*, 339 F.3d 129, 142 (2d Cir. 2003) (citation omitted); see *Guan*, 37 F.4th at 805 (addressing probable cause standard for involuntary hospitalization under mental health laws and describing an involuntary hospitalization under said laws as a "mental health arrest").

OMH Involuntary Removal Guidance

Although the OMH Involuntary Removal Guidance does not reference the standards requiring probable cause and danger to self or others that underpin a mental hygiene arrest under MHL § 9.41, the OMH Involuntary Removal Guidance specifies that for purposes of a § 9.41 mental hygiene arrest, "[l]ikelihood of serious harm includes: attempts/threats of suicide or self-injury; threats of physical harm to others; or other conduct demonstrating that the person is dangerous to him or herself, including a person's refusal or inability to meet his or her essential need for food, shelter, clothing or health care, **provided that such refusal or inability is likely to result in serious harm if there is no immediate hospitalization**" (emphasis added).[7]

[7] OMH Involuntary Removals Guidance at 3 (quoting *Matter of Scopes v. Shah*, 59 A.D.2d 203, 398 N.Y.S.2d 911 (3d Dep't 1977)). In *Matter of Scopes*, the Appellate Division's Third Department ruled that in order to satisfy substantive due process requirements, "the continued confinement of an individual must be based upon a finding that the person to be committed poses a real and present threat of substantial harm to himself or others.") *See also Matter of Carl C.*, 126 A.D.2d 640 (2d Dept 1987) ("State must prove, by clear and convincing evidence, that the person is mentally ill and that he poses a substantial threat of physical harm to himself (resulting) from a refusal or inability to meet his essential needs for food, clothing or shelter"); *Boggs v. Health Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (1st Dept. 1987) (noting that the sole issue before the court is whether, upon clear and convincing evidence, "Ms. Boggs is so severely mentally ill that, unless she continues to receive hospital treatment, she is in danger of doing serious harm to herself"). In the *Boggs* case, the evidence before the court presented a

The OMH Involuntary Removal Guidance relies on caselaw describing an individual's inability to meet their essential needs in the context of continued retention or involuntary admission of the person for psychiatric treatment. It notes that in order to satisfy substantive due process requirements, "the continued confinement of an individual must be based upon a finding that the person to be committed poses a real and present threat of substantial harm to himself or others, but that such a finding does not require proof of a recent overtly dangerous act."[8]

The NYC Removal Directive

As demonstrated above, the standard of proof set forth in caselaw and the OMH Involuntary Removal Guidance for what sort of risks rise to the level of "likely to result in serious harm" contemplate imminence ("immediate"), likelihood ("real and present"), and seriousness ("substantial harm" or "dangerousness"), rather than a long-running, speculative risk, or less significant harm.[9] OMH largely aligns with the caselaw when it articulates circumstances in which an "inability to meet essential needs" (also referred to as the "basic needs standard") could rise to that threshold. The NYC Removal Directive deviates significantly, sweeping in circumstances that are not as imminent, risky, or as substantial as those contemplated by caselaw or OMH, and therefore purports to authorize removals that will be legally indefensible.

The NYC Removal Directive notes that "case law does not provide extensive guidance regarding removals for mental health evaluations based on short interactions in the field" and then directs that the following circumstances "could be reasonable indicia": "serious untreated physical injury, unawareness or delusional misapprehension of surroundings, or unawareness or delusional misapprehension of physical condition or health." These are vague, broad, and undefined standards untethered to caselaw or any OMH interpretative guidance, and in particular, they do not incorporate the temporal urgency standard found in the latter source.

The City's December 6, 2022 FINEST message explaining the NYC Removal Directive to its police officers offers slightly more specificity.[10] It bears noting that, while this specificity is an

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combination of factors that led to the court's conclusion that there was justification for involuntary retention of Ms. Boggs in a psychiatric facility, i.e. Ms. Boggs was homeless and was allegedly living without sufficient clothing on a sidewalk grate in winter, running into traffic, making verbal threats to passersby, tearing up and urinating on money that passersby gave her, and covering herself in her own excrement.

[8] OMH Involuntary Removals Guidance at 2 (internal citation and quotation omitted).

[9] See the discussion of *Matter of Scopes* in note 7, *supra,* and the quoted language from *O'Connor* in the preceding section entitled "Constitutional Considerations" and the OMH Involuntary Removal Guidance in the section bearing that title.

[10] FINEST messages are read to police officers at roll call and are used to announce NYPD policy changes. Unlike the NYC Removal Directive, the instructions provided to officers in the FINEST message reference OMH's standard of temporal urgency (in one of the two relevant passages) and *O'Connor's* language with respect to survival. The FINEST message allows involuntary removal: "when the person appears mentally ill and incapable of meeting basic human needs to such an extent that the person is likely to suffer physical injury or serious harm **without immediate attention**" (emphasis added). The FINEST message provides as examples (without language of imminence of danger): "an incoherent person may be unable to assess and safely navigate their surroundings (e.g. avoiding oncoming traffic or subway tracks), may suffer from a serious untreated injury, or unable to seek out food, shelter or other things **needed for survival**" (emphasis added). A copy of the FINEST message, labeled SER#:

improvement on the NYC Removal Directive, it is only being distributed to one agency (NYPD), and the NYC Removal Directive purports to empower many city agencies (not just NYPD). Given the broader language found in the NYC Removal Directive and the Mayor's statements (discussed below), we remain concerned about the initiative's implementation across all agencies and future training at NYPD specifically.

These concerns are heightened because of the constitutional right (due process for deprivation of liberty) at stake. In contrast to the standards articulated in caselaw and the OMH Involuntary Removal Guidance, the NYC Removal Directive's basic needs standard is, in and of itself, insufficient to demonstrate immediate dangerousness to self or an incapability of surviving safely in the community. Given *O'Connor* and progeny, application of the basic needs standard absent sufficient indicia of dangerousness raises constitutional concerns. See also *Myers*, 819 F.3d at 632 (holding that a display of irrationality, annoyance, and a lack of cooperation was insufficient to imply dangerousness and to establish that the police acted with probable cause). The NYC Removal Directive's attempt to establish a link between basic needs and conduct likely to result in serious harm is analogous to the police's unsuccessful attempt to establish a link between dangerousness and behaviors unrelated to harm in *Myers.*[11]

II. The City's language announcing this initiative both reflects and will exacerbate bias against unhoused people and people with serious mental illness, in violation of anti-discrimination principles, and the NYC Removal Directive will disproportionately burden people of color.

City, State, and Federal law all prohibit discrimination on the basis of disability. The City Bar is concerned that the statements by key policymakers both accompanying the announcement of the NYC Removal Directive and subsequently explaining it will have a harmful effect in perpetuating negative public attitudes towards people with mental illness. The City Bar is further concerned that the NYC Removal Directive will disproportionately burden people of color who are unhoused or experiencing mental illness.

Anti-Discrimination Laws

City, State, and Federal law prohibit discrimination on the basis of disability, including mental illness, and require the City and other actors to provide reasonable accommodations to

42286935, was posted on the docket in the *Baerga et al. v. NYC et al.*, 21-cv-05762 (SDNY) (PAC) litigation, ECF/Docket # 123-1.

[11] There are, no doubt, legal risks that will be created by implementation of the NYC Removal Directive. Most directly, the NYC Removal Directive allows for seizures that will expose the City to liability for wrongful arrests. *See, e.g. Myers*, 819 F.3d at 633 (denying qualified immunity to a police officer where the record was insufficient to demonstrate arguable probable cause for the seizure and transfer to a psychiatric hospital). Additionally, prior experience has unfortunately but consistently shown that involuntary traumatizing interactions with law enforcement and other first responders have, in numerous instances, resulted in serious harm to both City employees and members of the public. This initiative will prompt incidents that are likely to result in additional City liability to its residents, through worker's compensation and tort litigation.

people with disabilities.[12] The NYC Removal Directive is at odds with the City's obligations under these laws in at least two distinct ways.

First, involuntary removals under the NYC Removal Directive could deny people access to public spaces such as the subway and the streets, based on their mental illness or the perception of it, in a much broader set of circumstances than is allowable under the Americans with Disabilities Act (ADA), and without the provision of reasonable accommodations. The ADA explicitly does not require an entity to include an individual who presents a "direct threat" meaning "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services." 42 U.S.C. § 12182(3). But the NYC Removal Directive covers a significant range of situations that cannot be categorized as falling within this narrow exception to the ADA's general requirement of inclusion.

Second, this initiative's focus on hospitalization in the absence of adequate and appropriate community-based services is inconsistent with both federal law and aligned state commitments to ensure the availability of community-based treatment options. The Supreme Court ruled in *Olmstead v. L.C.*, 527 U.S. 581 (1999)[13] that unnecessary institutionalization of people with disabilities is discrimination under the ADA. Simply stated, the ADA's "integration mandate" "requires that individuals with disabilities receive services in the most integrated setting appropriate to their needs."[14] OMH has acknowledged that this mandate necessitates a shift in New York's state mental health services towards greater community-based services.[15]

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[12] Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132, provides: "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." The City's Human Rights Law further provides: "it is an unlawful discriminatory practice for any person prohibited by the provisions of this section from discriminating on the basis of disability not to provide a reasonable accommodation to enable a person with a disability to . . . enjoy the right or rights in question provided that the disability is known or should have been known by the covered entity." N.Y.C. Admin. Code § 8-107(15)(a).

[13] The Court in Olmstead was encountering a remarkably similar circumstance to the issue at hand, where the plaintiffs, including Lois Curtis, a passionate self-advocate who recently passed away, cycled in and out of psychiatric hospitalization. "Lois and Elaine found themselves going in and out of the state's mental health hospitals dozens of times. After each stay in the hospital, they would go back home; but then, because they did not have help at home, they would start to struggle again and would have to go back to the hospital to get help again. Lois and Elaine asked the state of Georgia to help them get treatment in the community so that they would not have to go live at the state mental hospital off and on." Disability Integration Project of Atlanta Legal Aid Society, Brief History of Olmstead, https://www.olmsteadrights.org/about-olmstead/.

The Supreme Court stated in *Olmstead* that "unjustified institutional isolation of persons with disabilities is a form of discrimination" in part because "[i]n order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice." *Olmstead v. L.C.*, 527 U.S. at 600, 601.

[14] U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR), https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html.

[15] New York State HCBS [Home and Community-Based Services] Settings Transition Plan (2018) at pg. 195. "The legal system's expansion of civil rights to include people with mental illness, as part of Olmstead Legislation and Americans with Disabilities Act, has begun to move policy from the concept of least restrictive setting to full community inclusion. However, New York currently exceeds both the national average inpatient utilization rate at state-operated Psychiatric Centers (PCs), and per capita inpatient census levels at state-operated

Even assuming a person requires and would benefit from acute inpatient psychiatric services, there is a shortage of inpatient psychiatric beds in New York City, meaning that many people simply languish in psychiatric emergency rooms for longer. Some inpatient psychiatric wards take few Medicaid patients, which can make it harder to find beds for homeless people. The fundamental systemic issue, however, is that there are inadequate services and support for patients following their discharge from a hospital.[16] To that end, the City Bar welcomes Governor Hochul's recent announcement that hospitals and other inpatient providers will be required to develop a discharge plan that involves immediate wraparound services.

Disproportionate Effects on Communities of Color

The NYC Removal Directive may also implicate the City's obligations to refrain from engaging in practices that have a disparate effect on people of color. Data suggests policies like the NYC Removal Directive are likely to disproportionately impact Black and brown people.

People of color with disabilities are overrepresented in the population of individuals experiencing homelessness.[17] Black New Yorkers already make up 44% of the people currently receiving court-mandated treatment under one state law, though they're less than a quarter of the city's population. In New York City, "44% of current assisted outpatient treatment (AOT) recipients are Black and 32% are Latinx, according to state data."[18] This data suggest that Black and brown New Yorkers are much more likely to be subjected to forced removals from public spaces than white New Yorkers.

PCs in other urban states and all Mid-Atlantic States. . . . The OMH is in the process of creating the mental health system that New York needs in the 21st Century—a system focused on prevention, early identification and intervention, and evidence-based clinical services and recovery supports. OMH is rebalancing the agency's institutional resources to further develop and enhance community-based mental health services which are also consistent with the Americans with Disabilities Act (ADA). The US Supreme Court's 1999 Olmstead decision held that the ADA mandates that the State's services, programs, and activities for people with disabilities must be administered in the most integrated setting appropriate to a person's needs." Available at: https://www.health.ny.gov/health_care/medicaid/redesign/hcbs/docs/2018-05-18_hcbs_final_rule.pdf.

[16] Andy Newman and Joseph Goldstein, *Can New York's Plan for Mentally Ill Homeless People Make a Difference?,* New York Times, December 15, 2022, https://www.nytimes.com/article/nyc-homeless-mental-health-plan.html.

[17] Basic Facts about Homelessness, Coalition for the Homeless, updated December 2022, https://www.coalitionforthehomeless.org/basic-facts-about-homelessness-new-york-city/. *See also* Stacy M. Brown, *Blacks Hit Hardest as NYC's Homeless Population Grows Amid Mental Health Crisis* (Mar. 23, 2022), https://www.washingtoninformer.com/blacks-hit-hardest-as-nycs-homeless-population-grows-amid-mental-health-crisis/.

[18] *See* Ethan Geringer-Sameth, *What's Behind the Increased Use of Kendra's Law in New York City?*, Gotham Gazette, September 27, 2022, https://www.gothamgazette.com/state/11599-increase-kendras-law-new-york-city?utm_source=The+Marshall+Project+Newsletter&utm_campaign=703deaa159-EMAIL_CAMPAIGN_2022_12_16_05_14&utm_medium=email&utm_term=0_5e02cdad9d-703deaa159-%5BLIST_EMAIL_ID%5D.

Bias and Stereotyping

In their public explanations of this initiative, the mayor and public entities have focused on two primary justifications. The first is, according to the mayor, the "moral obligation" to connect severely mentally ill New Yorkers to appropriate care and housing. We support the removal of barriers to accessing care and stable housing for those who need them. The second justification, however, has included the repeated use of stigmatizing language that relies upon stereotypes and exacerbates bias. These statements, quoted below, reflect a shared and fundamentally flawed premise, which is an erroneous belief that those experiencing mental illness definitionally constitute a threat to the personal safety of others.

Inability to meet *one's own* basic needs is not indicative of dangerousness *to others*. As noted above, both the MHL and caselaw provide for distinct lanes of analysis for whether someone constitutes a threat to *themselves* and whether someone constitutes a threat to *others*, and do not countenance unjustified slippage between these concepts.[19] The OMH Involuntary Removal Guidance explicitly identifies inability to meet one's needs as potential evidence of a risk of danger to oneself, rather than as evidence of a danger to others: "conduct demonstrating that the person is dangerous to him or herself, including a person's refusal or inability to meet his or her essential need for food, shelter, clothing or health care, . . ."[20] Despite popular perceptions and fears, empirical data connecting even severe mental illness with an increased risk of perpetrating interpersonal violence is inconclusive, and an appropriate assessment of dangerousness is necessarily highly individualized.[21]

The mayor's statements at the press conference announcing this new initiative present a fundamental misconception and improperly conflate mental illness and interpersonal violence: "There's nothing dignified about using a corner of a tent as a restroom or having month-old food sitting there or talking to yourself, being delusional, or waiting until you carry out a dangerous act before we respond. That is just so irresponsible that **we know that this person is about to probably go off the edge and harm someone** but we're going to wait until it happened."[22]

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[19] *See supra* note 4 quoting MHL § 9.41: "'Likelihood to result in serious harm' shall mean (1) substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is **dangerous to himself, or** (2) a substantial risk of physical harm **to other persons** as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm" (emphasis added).

Though both the FINEST message and the NYC Removal Directive repeat the MHL's general language of "harm to themselves or others" there is nothing in either document suggesting that self-neglect would indicate a risk of harm to others, and in fact the FINEST message is quite clear that the risk of harm contemplated by the initiative is "to that person."

[20] OMH Involuntary Removals Guidance at 3.

[21] *See, e.g.,* Varshney M, Mahapatra A, Krishnan V, et al. *Violence and Mental Illness: What is the True Story?* J Epidemiology & Community Health 2016; 70:223-225, https://jech.bmj.com/content/70/3/223.

[22] "Address on the Mental Health Crisis in New York City" transcript available at: https://www.nyc.gov/office-of-the-mayor/news/871-22/transcript-mayor-eric-adams-delivers-address-mental-health-crisis-new-york-city-holds (cited *supra*, n. 2) (emphasis added).

Governor Hochul, in announcing funding for mental health services, similarly conflated general public discomfort with individualized assessments of danger, describing "a public safety crisis" stemming from underfunding of mental health services, and pointing to the public feeling "anxious" about encountering people with mental health conditions while on the subway as evidence thereof.[23]

Unfortunately, these descriptions of the initiative by elected officials -- as well as others that have appeared in both City and State published documents[24] -- have the effect of perpetuating bias. The Mayor, the Governor, and the *Making New York Work for Everyone* report, which was the culmination of months of collaboration among a panel "of civic leaders and industry experts"[25] (although the list of panel contributors does not include experts in mental health treatment or leaders of disability advocacy organizations) have repeated harmful stereotypes about people with mental illness. As the New York City Bar Association has stated in other contexts, "Words matter because they reflect thought and drive action."[26] The disability rights community has a motto: "nothing about us without us," which calls for the meaningful involvement of people with disabilities in the development of policy that impacts them. We call on City leaders to repudiate bias and commit to inclusive decision-making in its future efforts relating to mental illness.

As discussed further below, this new initiative arrives in the context of the City's inadequate provision of voluntary, community-based mental health treatment options, which has resulted in the inaccessibility of low-cost care and long waiting lists. Governor Hochul's State of the State included an announcement of new funding for inpatient and outpatient mental health

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[23] Destra, Shantel, "Lawmakers welcome Hochul's $1 billion to address mental health," City & State NY, Jan. 11, 2023, https://www.cityandstateny.com/policy/2023/01/lawmakers-welcome-hochuls-1-billion-address-mental-health/381708/.

[24] Similarly, the City's Subway Safety Plan notes as an impetus for this initiative the perceptions of the public: "Second, our subways must be safe and feel safe for every person who enters them . . . . Our city's prosperity depends on everyone feeling confident and secure when they enter a station." Subway Safety Plan at 4, https://www1.nyc.gov/assets/home/downloads/pdf/press-releases/2022/the-subway-safety-plan.pdf (cited *supra*, n. 6).

A joint City and State report *Making New York Work for Everyone* released this month similarly states: "Concerns about safety and quality of life can stymie economic prosperity in terms of investment, revenue, and overall economic activity. We must acknowledge that many residents, commuters, and business owners have been increasingly concerned for their safety and that of their employees as they move around the city." *Making New York Work for Everyone*, December 2022, at pg. 42, https://edc.nyc/sites/default/files/2022-12/New-NY-Action-Plan-Making_New_York_Work_for_Everyone.pdf. Conflating again the concepts of risk of harm to self and harm to others, the report states: "As part of the [NYC Removal Directive] plan, the Mayor issued a directive to outreach workers, City-operated hospitals, and first responders clarifying that they have the legal authority to provide care to New Yorkers when severe mental illness prevents them from meeting their own basic human needs to the extent that they are a danger to themselves **or others**" (emphasis added). *Id*. at 44.

[25] *Making New York Work for Everyone* at 4.

[26] President's Column (Winter 2021) by former City Bar President Sheila Boston, https://digital.nycbar.org/44thstreetnotes/winter-2021/launch-of-the-six-priorities/. *See also* Statement of New York City Bar Association on Reckless Statements and Their Impact in the Charged Environment Surrounding the Mar-A-Lago Search (August 24, 2022) ("words matter and have consequences") *and* Statement of New York City Bar Association on The Disturbing Trend of Threats and Violence Against Judges and the Vital Importance of Judicial Security (June 24, 2022) ("today we urge all Americans, particularly public officials and members of the legal profession, to remember that in public discourse our words matter.").

services, as well as funding for affordable housing.[27] These investments are welcome and will, in time, reduce barriers to treatment and stable housing; at the same time, the effects of decades of underfunding for these services will require time and sustained investment to reverse.

III. This initiative directs resources into a failed strategy, at a time when the City has reduced investments in effective strategies that connect people to long term treatment and care.

Numerous groups and individuals with lived experience, both people with mental illness or those with experience providing treatment, have cautioned that increasing involuntary commitments will hinder, rather than improve, our ability to successfully connect people with care.[28]

Fortunately, there are alternative approaches that will remove barriers to accessing care and stable housing for people experiencing mental illness. As the Bazelon Center has noted,[29] research indicates that high-quality engagement of homeless people with mental health conditions, such as that provided through New York's Street Homeless Advocacy Project,[30] which sends people with lived experience with homelessness back to the streets to help others, helps individuals see the value of and agree to participate in supportive services.[31] Safe, stable, and affordable housing, provided with voluntary supports, has been shown to help homeless New Yorkers and

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[27] Press Release, "Governor Hochul Announces Comprehensive Plan to Fix New York State's Continuum of Mental Health Care," Jan. 10, 2023, https://www.governor.ny.gov/news/governor-hochul-announces-comprehensive-plan-fix-new-york-states-continuum-mental-health-care.

[28] *See, e.g.* Fountain House Calls for Comprehensive Mental Health Care in Response to Mayor Adams' Directive on Involuntary Removals, December 1, 2022. "[T]he approaches announced this week will not address the revolving doors to hospitals and jails, and can further stigmatize and isolate people living with serious mental illness." Available at https://www.fountainhouse.org/news/fountain-house-statement-on-mayor-adams-directive-to-expand-involuntary-removals; Anthony Almojera, *I'm an N.Y.C. Paramedic. I've Never Witnessed a Mental Health Crisis Like This One*, The New York Times (guest essay), December 7, 2022. "I'm not opposed to taking mentally ill people in distress to the hospital; our ambulances do this all the time. But I know it's unlikely to solve their problems . . . . While I don't know how forcing people into care will help, I do see how it will hurt. Trust between a medical responder and the patient is crucial. Without it, we wouldn't be able to get patients to talk to us, to let us touch them or stick needles filled with medications into their arms. But if we bundle people into our ambulances against their will, that trust will break." Available at: https://www.nytimes.com/2022/12/07/opinion/nyc-paramedic-mental-health-crisis.html?smid=nytcore-ios-share&referringSource=articleShare.

[29] Judge David L. Bazelon Center for Mental Health Law, *Mayor Adams' Plan Will Not Help New Yorkers With Mental Disabilities*, December 22, 2022, http://www.bazelon.org/wp-content/uploads/2022/12/BC-NYC-Statement-12-2-22.pdf.

[30] *See* Forum Staff, *City Launches Homeless Advocacy Project*, The Forum (Jul. 21, 2022), http://theforumnewsgroup.com/2022/07/21/city-launches-homeless-advocacy-project/.

[31] *See, e.g.,* Center for Court Innovation, *The Myth of Legal Leverage?* ("Studies of therapeutic intervention strongly suggest that the quality of the human interaction outweighs the importance of any particular protocol or approach…." "factors like goal consensus, empathy, alliance, and positive regard are significantly greater than, say, model fidelity," and "a robust therapeutic relationship is less a matter of dosage and more a matter of engagement."), https://www.courtinnovation.org/sites/default/files/media/documents/2020-04/report_the_myth_of_legal_leverage_04232020.pdf.

others stabilize and avoid hospitalization and incarceration.[32] And longer-term services, such as assertive community treatment (ACT), supported employment, and peer support services—delivered not in the hospital, but in the person's own home and community—have been shown to break the cycle of institutionalization.[33]

Yet a report issued by New York City's Public Advocate in November 2022 indicated that the city has reduced the scope of effective evidence-based strategies that would better address mental health crises. There are now only four community- and peer-led Respite Care Centers in the five boroughs of the city, down from eight such centers in 2019.[34] There are only 19 behavioral health mobile crisis teams (MCTs) that can respond to calls for help instead of the police, serving the entire city in 2022, down from 24 teams in 2019.[35]

While the City has a pilot program to send teams of alternative first responders to 911 calls related to mental health crises, these "B-HEARD" teams have a limited scope and capacity. They only responded to 16 percent of 911 calls related to mental health crises in the few Manhattan neighborhoods where they are being piloted, and they have a response time that is not comparable with that of the police.[36]

The Public Advocate's report found that the city is "lagging behind in providing supportive housing, with an often-delayed application process,"[37] and "lagging in the inclusion of peers with lived-in experiences into the city's mental health programs."[38] The Correct Crisis Intervention Today - New York City (CCIT-NYC) coalition, which is made up of civil rights and human service organizations, people with lived experience with mental health crises, family members, and other advocates, has advocated for a decade to increase the availability of evidence-based, peer-led responses to mental health crises.[39] "The City has the power to provide onsite treatment, as well as treatment in homeless shelters or supported housing, but has chosen not to."[40] We note that

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[32] S. Tsemberis & R.F. Eisenberg, *Pathways to Housing: Supported Housing for Street-dwelling Homeless Individuals with Psychiatric Disabilities,* Psychiatric Services Vol. 51, Issue 4, 487-93, https://doi.org/10.1176/appi.ps.51.4.487.

[33] Bazelon Center for Mental Health Law, *Diversion to What? Evidence-Based Mental Health Services that Prevent Needless Incarceration* (September 2019), http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf.

[34] Office of the Public Advocate, *Improving New York City's Response to Individuals in Mental Health Crisis 2022 Update 3* (November 2022) at pg. 3, https://advocate.nyc.gov/static/assets/Mental_Health_Updates_2022c.pdf.

[35] *Id*. at 5.

[36] *Id*. at 7-8.

[37] *Id*. at 5.

[38] *Id*. at 10.

[39] https://www.ccitnyc.org/.

[40] National Alliance on Mental Illness – NYC, NAMI-NYC Calls for Comprehensive, Person-Centered Behavioral Health Care for People Living with Serious Mental Illness, November 29, 2022, https://naminycmetro.org/involuntaryremoval/.

these shortcomings may be addressed by Governor Hochul's recent announcement of significant funding for community-based mental health services and supportive housing.

Just last month, the United States Interagency Council on Homelessness released a comprehensive report entitled *All In: The Federal Strategic Plan to Prevent and End Homelessness* (the *All In* report).[41] It notes that local officials have responded to a rise in the number of people living in unsheltered locations "not always in the most effective ways" through "out of sight, out of mind" policies that displace people without successfully connecting them to evidence-based services.[42] The mayor's initiative fits broadly within the parameters of effectively criminalizing homelessness, which the *All In* report identifies as counterproductive. Such policies take away resources from constructive solutions to homelessness, create trauma, can erect financial and criminal legal barriers for people seeking pathways out of housing insecurity and homelessness, and disproportionately burden already-marginalized communities including people of color, LGBTQI+ people and people with disabilities.

* * *

In conclusion, we ask for a commitment from the City to pause its rushed implementation of this initiative, and take seriously the concerns raised by individuals with lived experience of mental illness and/or homelessness following the announcement. In the coming months, our committees, like many interested New Yorkers, will carefully evaluate the City's proposed legislative and operational changes, and would welcome the opportunity to meet with city attorneys to discuss these legal issues. There are evidence-based solutions available to the City to better support people accessing care and housing. We call on the City to halt this removal initiative and instead pursue effective strategies within its legal authority.

Civil Rights Committee
Kevin Eli Jason and Kathleen Rubenstein, Co-Chairs

Disability Law Committee
Katherine Rose Carroll, Chair

Mental Health Law Committee
Mikila J. Thompson, Chair

New York City Affairs Committee
Erik Rubinstein, Secretary[43]

Social Welfare Committee
Lindsay Funk and Sandra Gresl, Co-Chairs

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[41] United States Interagency Council on Homelessness, *All In: The Federal Strategic Plan to Prevent and End Homelessness* (December 2022), https://www.usich.gov/All_In_The_Federal_Strategic_Plan_to_Prevent_and_End_Homelessness.pdf.

[42] *Id*. at 20.

[43] The Chair and a number of members of the New York City Affairs Committee recused themselves from discussion and voting on this letter.

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New York City Council Hearing - Committee on Mental Health, Disabilities, and Addiction – Jointly with the Committee on Public Safety, Hospitals, and Fire & Emergency Management

February 6th, 2023

Good afternoon, Chair Lee, Chair Narcisse, Chair Ariola, Chair Hanks, and Committee members. Thank you for allowing me to testify today. My name is Helen 'Skip" Skipper – I am the Executive Chair of the NYC Justice Peer Initiative – where I am building a new workforce out of folks impacted by the criminal justice system and transforming service delivery of said system and aiding in the decriminalization of behavioral health. I am appearing before you today to give testimony protesting this latest iteration perpetuating the criminalization of community members with behavioral health concerns. Let me be intentional and absolutely clear– I speak of myself! The criminal justice system, the mental health system, the substance abuse system, and the homelessness system directly impact me!!!! I am a NYC resident – born and raised, and as much as I love my city – I fully understand my city does not love people like me – we are relegated to 2nd class citizenship based on our lived experiences in these traumatizing systems. I spent 25 years cycling in and out of these systems without access to treatment and support. But we are still residents of this city. Plans are now being made to take away our voice and choice – to take away our agency by involuntarily confining us – by changing laws to give the decision-making power of involuntary confinement to those who are not adequately trained and educated enough to discern whether we are a danger to ourselves and others – LAW ENFORCEMENT HAS AN EXTENSIVE HISTORY OF FATAL INTERACTION WITH THOSE WHO ARE TERMED "EMOTIONALLY DISTURBED"! THE MAYOR PROPOSES TO EXPAND THIS INVOLVEMENT! CAN WE EVEN STOP & PAUSE TO THINK ABOUT THE AMOUNT OF TIME AND TRAINING IT WOULD TAKE TO TRAIN THEM ADEQUATELY? I would like us to pause and reflect on what the city did not provide that led to this moment in time? We need to be trauma-informed- an evidence-based practice that works. That entails not focusing on what happened but on what caused it to happen? Or what happened to that individual? Or more specifically what didn't happen? Again – keeping in that same vein of being authentically open and honest – there have been a few incidents in question – why are we running screaming for the hills instead of reflecting what we as the city did not do to protect our most vulnerable citizenry– and why are we not shoring up the supports and services needed? Instead of involuntary confinement and coercion, we need housing – we need community-based supports & services – we need peers who have lived experience and who are the subject matter experts in the room like myself – we do not need the police who are not trained to make clinical decisions. 1 in 5 people suffer from Mental health concerns – we need an expanded, more adequately trained, and sufficiently compensated behavioral health workforce. We need better communication between city agencies that are tasked with the care of vulnerable people – we don't need pie-in-the-sky plans designed to criminalize and take away someone's voice and choice – WE NEED SERVICES AND SUPPORTS!

NYCLU
ACLU of New York

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Testimony of Beth Haroules On Behalf of the New York Civil Liberties Union Before the New York City Council Committees on Public Safety, Mental Health, Disabilities and Addiction, Fire and Emergency Management and Hospitals Regarding Oversight -- Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan.

February 6, 2023

The New York Civil Liberties Union (NYCLU) appreciates this opportunity to submit the following testimony regarding Mayor Adams' new directive on "mental health involuntary removals" (the "NYC Mental Health Involuntary Removals Policy").[1]

The NYCLU, the New York State affiliate of the American Civil Liberties Union, is a not-for-profit, nonpartisan organization with eight offices throughout the state and over 85,000 members and supporters. The NYCLU defends and promotes the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution, and the New York Constitution, including the right of every New Yorker to enjoy life, liberty, due process, and equal protection under law. This includes our work in pursuit of community safety, and our work to advance the rights of New Yorkers with disabilities and New Yorkers who are unhoused.

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[1] On November 29, 2022, Mayor Adams held a press conference to "Address [...] the Mental Health Crisis in New York City." *See* Transcript, https://www.nyc.gov/office-of-the-mayor/news/871-22/transcript-mayor-eric-adams-delivers-address-mental-health-crisis-new-york-city-holds.

There was a 5 page directive released at this press conference captioned *Mental Health Involuntary Removals, as of 11/28/2022*, https://www.nyc.gov/assets/home/downloads/pdf/press-releases/2022/Mental-Health-Involuntary-Removals.pdf (the "Policy Directive").

The only other publicly available document relating to the NYC Mental Health Involuntary Removals Policy is an NYPD FINEST message dated December 6, 2022 (FINEST message). The FINEST message was filed in the electronic case docket in *Baerga et al. v. NYC et al.*, 21-cv-05762 (SDNY)(PAC) at ECF/Docket # 123-1. A copy of the FINEST message is attached to this testimony.

No other information has been made available by any of the other City agencies, including FDNY/EMS, DSS, DOHMH, and the NYC Sheriff, as well as H+H and the MTA and MTA Police, that have all been directed to initiate this new policy.

Our comments today will address the following matters with respect to the NYC Mental Health Involuntary Removals Policy:

- the NYC Mental Health Involuntary Removals Policy **directs resources into a failed strategy** of involuntary psychiatric hospitalization and forced treatment, at a time when the City has continued to reduce or eliminate investment in effective strategies that connect people to long term treatment and care
- the NYC Mental Health Involuntary Removals Policy, as written and as discussed by Mayor Adams and Governor Hochul, **allows removals that are not justified** under the U.S. Constitution or New York State Mental Hygiene Law
- the NYC Mental Health Involuntary Removals Policy, as written and as discussed by Mayor Adams and Governor Hochul, **reflects and will exacerbate bias** against unhoused people and people with mental illness and will disproportionately burden New Yorkers of color
- as with many of this Administration's immoral initiatives directed at people who are unhoused and at people with disabilities, there has been from the start **a complete lack of transparency, clear processes, and failure of data collection and reporting**; rather information is released via press conference and via highly controlled and selective disclosure to chosen media outlets.

Finally, we offer brief comments with respect to Int. 0273-2022 and Int. 0706-2022 which are also on the agenda for today's hearing.

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Introduction

With the NYC Mental Health Involuntary Removals Policy, the Adams Administration is playing fast and loose with the legal rights of New Yorkers and is not dedicating the resources necessary to address the mental health crises that affect our communities. The federal and state constitutions impose strict limits on the government's ability to detain people experiencing mental illness – limits that the Mayor's new initiative is likely to violate.

Forcing people into treatment is a failed strategy for connecting people to long-term treatment and care. Unless we adequately invest in the long-term health and well-being of New Yorkers facing mental illness and our chronic lack of housing, the current mental health crisis will continue. The decades-old practice of sweeping deep-seated problems out of public view may play well for the politicians, but the problems will persist – for vulnerable people in desperate need of government services and for all New Yorkers.

The Mayor's attempt to police away homelessness and sweep individuals out of sight is a page from the failed playbook of countless Mayoral administrations before his. With no real plan for housing, services, or supports, the administration is choosing handcuffs and coercion. It is magical thinking to assume that the subways and the streets will not function as housing when the City and state simply offer nothing other than involuntary transport to a psychiatric facility for "observation" under threat of compelled inpatient psychiatric treatment. The broader housing goals offered, last year and this year, by Governor Hochul and Mayor Adams will take far longer to implement while NYPD enforcement activities have essentially ramped up overnight.

We urge the City Council to continue to keep intense focus on the investment of resources and connection of people with consensual care – proven approaches to help people in the long term. And we urge the City Council to push back against what appears to be the Mayor's and Governor's intent to recraft a mental health system to permit easier removal and forced treatment of people without addressing systematic dysfunctionality – the lack of supportive housing and culturally appropriate supports and services. Short-term forced treatment and criminalization are demonstrably ineffective approaches to meaningful change. New Yorkers need more direct access to economic, health and care resources -- not more police.

1. **The NYC Mental Health Involuntary Removals Policy Directs Resources into a Failed Strategy of Involuntary Psychiatric Hospitalization and Forced Treatment, at a Time When the City has Continued to Reduce or Eliminate Investment in Effective Strategies that Connect People to Long Term Treatment and Care**

Individuals with lived experience, service providers and advocacy groups, all too numerous to detail here, have cautioned that increasing involuntary commitments will actually hinder, rather than improve, the City's ability to successfully connect people with care.[2]

This is not a new issue and we and countless advocates in this field can point the Council to over forty years of research demonstrating the success of modes of engagement with unhoused individuals experiencing mental health challenges that does result in consensual participation in treatment that is delivered in non-inpatient institutional settings and in the least restrictive setting appropriate to a person's needs.

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[2] *See, e.g.* Fountain House Calls for Comprehensive Mental Health Care in Response to Mayor Adams' Directive on Involuntary Removals, December 1, 2022. "[T]he approaches announced this week will not address the revolving doors to hospitals and jails, and can further stigmatize and isolate people living with serious mental illness." https://www.fountainhouse.org/news/fountain-house-statement-on-mayor-adams-directive-to-expand-involuntary-removals; Anthony Almojera, I'm an N.Y.C. Paramedic. I've Never Witnessed a Mental Health Crisis Like This One, The New York Times (guest essay), December 7, 2022, https://www.nytimes.com/2022/12/07/opinion/nyc-paramedic-mental-health-crisis.html?smid=nytcore-ios-share&referringSource=articleShare. Mr. Almojera emphasized the need to develop therapeutic alliances, noting "[t[rust between a medical responder and the patient is crucial. Without it, we wouldn't be able to get patients to talk to us, to let us touch them or stick needles filled with medications into their arms. But if we bundle people into our ambulances against their will, that trust will break."

Yet, even assuming a person requires and would benefit from a short period of acute inpatient psychiatric stabilization services, there is a shortage of inpatient psychiatric beds in New York City. Governor Hochul, in fact, took the private hospitals to task at last week's press conference discussing her "Cops, Cameras, Care" initiative, as the Subway Safety Plan was rebranded, She noted that the care connection piece was lagging because hospitals, who received significant rate adjustments in last year's budgets, tend to shun Medicaid patients to receive services in the few private inpatient psychiatric settings, which can make it harder to find beds for homeless people. The January 27, 2023 press conference is https://www.governor.ny.gov/news/governor-hochul-and-mayor-adams-announce-significant-progress-subway-and-transit-public-safety.

Families and advocates have long pointed out that many people simply languish in psychiatric emergency rooms for longer. The fundamental systemic issue, however, is that there are inadequate services and support for patients following their discharge from inpatient settings. Andy Newman and Joseph Goldstein, Can New York's Plan for Mentally Ill Homeless People Make a Difference?, New York Times, December 15, 2022, https://www.nytimes.com/article/nyc-homeless-mental-health-plan.html.

The Bazelon Center issued a report objecting to the NYC Mental Health Involuntary Removals Policy that provides citations to a raft of research that indicates the success to be found with high-quality engagement of homeless people with mental health conditions.[3] One such successful approach is that deployed by the New York's Street Homeless Advocacy Project, a peer-led street engagement process that has successfully connected street homeless people to supportive services.[4] Safe, stable, and affordable housing, provided with voluntary supports, has always been shown to help unhoused New Yorkers with mental health challenges, and others, stabilize and avoid hospitalization and incarceration.[5] A menu of longer-term services, such as assertive community treatment (ACT), supported employment, and peer support services—delivered not in the hospital, but in the person's own home and community—have been shown to break the cycle of institutionalization.[6] Low barrier/no barrier supportive housing is also a critical part of the equation.[7]

Regrettably, the City has actually reduced the scope of effective evidence-based strategies that would better address mental health crises. We respectfully direct the Council's attention to the report issued by New York City's Public Advocate in November 2022. [8] The Public Advocate's comprehensive report notes that there are now only four community- and peer-led Respite Care

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[3] Judge David L. Bazelon Center for Mental Health Law, *Mayor Adams' Plan Will Not Help New Yorkers With Mental Disabilities*, December 22, 2022, http://www.bazelon.org/wp-content/uploads/2022/12/BC-NYC-Statement-12-2-22.pdf. *See also* Center for Court Innovation, *The Myth of Legal Leverage?* ("Studies of therapeutic intervention strongly suggest that the quality of the human interaction outweighs the importance of any particular protocol or approach...." "factors like goal consensus, empathy, alliance, and positive regard are significantly greater than, say, model fidelity," and "a robust therapeutic relationship is less a matter of dosage and more a matter of engagement."), https://www.courtinnovation.org/sites/default/files/media/documents/2020-04/report_the_myth_of_legal_leverage_04232020.pdf

[4] *See* Forum Staff, *City Launches Homeless Advocacy Project*, The Forum (Jul. 21, 2022), http://theforumnewsgroup.com/2022/07/21/city-launches-homeless-advocacy-project/.

[5] S. Tsemberis & R.F. Eisenberg, *Pathways to Housing: Supported Housing for Street-dwelling Homeless Individuals with Psychiatric Disabilities,* Psychiatric Services Vol. 51, Issue 4, 487-93 (2000), https://doi.org/10.1176/appi.ps.51.4.487.

[6] Bazelon Center for Mental Health Law, *Diversion to What? Evidence-Based Mental Health Services that Prevent Needless Incarceration* (September 2019), http://www.bazelon.org/wp-content/uploads /2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf.

[7] *See* Coalition for the Homeless, *State of the Homeless 2022: New York at a Crossroads*, https://www.coalitionforthehomeless.org/state-of-the-homeless/. The report by the Coalition for the Homeless, the plaintiff in the *Callahan* case establishing the right to shelter in New York City, offers a robust menu of housing types that are necessary to meet the needs of unhoused New Yorkers.

The Council is no doubt aware that Governor Hochul's recently released budget proposal setting out funding for a variety of supportive housing opportunities raises more questions than it answers. It is unclear how this proposal fits into or advances last year's launch of a comprehensive, $25 billion housing plan which then included a $25 billion, five-year housing plan intended to create or preserve 100,000 affordable homes across New York, including 10,000 with support services for vulnerable populations. *See e.g.* https://www.governor.ny.gov/news/governor-hochul-announces-launch-comprehensive-25-billion-housing-plan-historic-fy-2023-budget.

This year's proposal is to create some 3,500 new housing units for individuals with mental illness. The proposed units are largely transitional housing, not stable long-term or permanent opportunities; nor are they no-barrier or low-barrier. There is also a 5 year development time attached to the scatter site housing opportunities which represent more than 50% of the units proposed to be created.

[8] Office of the Public Advocate, *Improving New York City's Response to Individuals in Mental Health Crisis 2022 Update 3* (November 2022) at pg. 3, https://advocate.nyc.gov/static/assets/Mental_Health_Updates_2022c.pdf.

Centers in the five boroughs of the city, down from eight such centers in 2019. There are only 19 behavioral health mobile crisis teams (MCTs) that can respond to calls for help instead of the police, serving the entire city in 2022, down from 24 teams in 2019.[9] And, while the City has a pilot program to send teams of alternative first responders to 911 calls related to mental health crises, these "B-HEARD" teams have a limited scope and capacity. B-HEARD teams responded to only16 percent of 911 calls related to mental health crises in the few Manhattan neighborhoods where they are being piloted, and they have a response time that is not even comparable with that of the police.[10]

The Public Advocate's report found that the city is "lagging behind in providing supportive housing, with an often-delayed application process,"[11] and "lagging in the inclusion of peers with lived-in experiences into the city's mental health programs."[12] NAMI-NYC has noted that "the City has the power to provide onsite treatment, as well as treatment in homeless shelters or supported housing, but has chosen not to."[13] The Correct Crisis Intervention Today - New York City (CCIT-NYC) coalition, which is made up of civil rights and human service organizations (including the NYCLU), people with lived experience with mental health crises, family members, and other advocates, has advocated for a decade to increase the availability of evidence-based, peer-led responses to mental health crises.[14] "Daniel's Law," of course, is an example of a statewide initiative that would provide the opportunity to meet this moment with a bold new vision for community safety that starts with removing police as the default solution to address mental health needs, placing the power to design, implement, and monitor peer-infused crisis response systems.[15]

We also respectfully direct the Council's attention to a comprehensive report from the United States Interagency Council on Homelessness titled *All In: The Federal Strategic Plan to Prevent and End Homelessness*.[16] The Interagency Council notes that local officials have responded to a rise in the number of people living in unsheltered locations "not always in the most effective ways" through "out of sight, out of mind" policies that displace people without successfully connecting them to evidence-based services.[17] This is precisely a description of the City's NYPD-led homeless sweeps initiatives to date, initiatives that clearly fall within the parameters of criminalization of homelessness which the Interagency Council notes is a completely counterproductive approach to a pressing social issue.

Importantly, these "out of sight out of mind" policies take away resources from constructive solutions to homelessness, create trauma, can erect financial and criminal legal barriers for

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[9] *Id.* at 5.
[10] *Id.* at 7-8.
[11] *Id.* at 5.
[12] *Id.* at 10.
[13] National Alliance on Mental Illness – NYC, NAMI-NYC Calls for Comprehensive, Person-Centered Behavioral Health Care for People Living with Serious Mental Illness, November 29, 2022, https://naminycmetro.org/involuntaryremoval/.
[14] *See* https://www.ccitnyc.org/.
[15] "Daniel's Law," A.2210 (Bronson) / S.2398 (Brouk), https://legislation.nysenate.gov/pdf/bills/2023/S2398.
[16] United States Interagency Council on Homelessness, *All In: The Federal Strategic Plan to Prevent and End Homelessness* (December 2022) https://www.usich.gov/All_In_The_Federal_Strategic_Plan_to_Prevent_and_End_Homelessness.pdf.
[17] *Id.* at 20.

people seeking pathways out of housing insecurity and homelessness, and disproportionately burden already-marginalized communities including people of color, LGBTQI+ people and people with disabilities.[18]

The NYC Mental Health Involuntary Removals Policy must be assessed in the context of the City's enormous significant cuts to critical services and safety net programs New Yorkers need, while simultaneously funding NYPD overspending and enabling NYPD impunity by decreasing funding for police oversight and accountability.

We need the Speaker and City Council to ensure that the FY24 Budget restores and protects critical services and programs that our communities rely on and that are essential for the full recovery of our city, which has resulted in the inaccessibility of low-cost care and long waiting lists. Since Mayor Adams took office he has been steadily cutting personnel, positions and funding from our public schools, homeless and housing services, police oversight, libraries, mental health services, services for the aging, and other critical programs. Concurrently, he has continued to expand the NYPD's resources to advance discriminatory policing practices that fail to meaningfully and systemically address safety concerns of New Yorkers, while working to increase the role of the NYPD in providing social and health services that are best handled by care workers and other expert professionals.

New Yorkers need more direct access to economic, health and care resources -- not more police.

2. The Federal and State Constitutions Impose Strict Limits on the Government's Ability to Detain People Experiencing Mental Illness – Limits that the NYC Mental Health Involuntary Removals Policy Violates.

A highly complex web of federal and New York State constitutional provisions, various federal and New York State statutes, agency guidance issued by the New York State Office of Mental Health ("OMH") as well as federal court and state court caselaw sets strict parameters to guard individual rights when the government exercises its police power to effect the involuntarily detention and involuntary and forcible treatment of an individual on the basis of their mental health.

Not only is the NYC Mental Health Involuntary Removals Policy approach lacking in substantive merit as detailed above, as written it also flies in the face of these long-established legal protections.[19]

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[18] *Id.* at 20.

[19] We note that the legal analysis we provide, in this section and the following section of our testimony, is based on the extremely limited information currently known about the NYC Mental Health Involuntary Removals Policy, i.e. the Policy Directive, the FINEST message, and the ongoing public discussion of the policy by Mayor Adams and other elected officials. The NYCLU has FOILed all the agencies identified in the Policy Directive for information relating to the NYC Mental Health Involuntary Removals Policy and we have been stonewalled by the agencies, either failing to respond by the dates originally identified or pushing out preliminary response dates to May 1, 2023 (NYPD) and May 4, 2023 (FDNY/EMS). As we will see we end our testimony today urging the Council to ensure there is robust data reported to ensure transparency as to the details of the NYC Mental Health Involuntary Removals Policy and its implementation. The data we urge the Council to require from the Administration is critical

Background

Article 9 of the New York State Mental Hygiene Law ("MHL") provides authority for so-called "mental hygiene arrests." MHL § 9.41 authorizes law enforcement offices, such as the NYPD, to detain and transport people in custody for psychiatric evaluations. MHL § 9.58 authorizes designated clinicians to direct law enforcement officers, such as the NYPD, to carry out the removal of individuals to a hospital for evaluation.

These two provisions, which form the lynchpin of the NYC Mental Health Involuntary Removals Policy, both provide that an involuntary removal may occur when any person "appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others." MHL §§ 9.41 and 9.58.[20]

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to further analysis as to whether the implementation of the Policy has actually resulted in the legal violations we identify in our testimony.

[20] Like most of the provisions of MHL Article 9 which governs the involuntary admission and treatment of people experience mental health challenges, MHL § 9.41 and MHL § 9.58 rest on the definitional construct of "danger" to self or others.

Section 9.41 provides as follows:

§ 9.41 Emergency assessment for immediate observation, care, and treatment; powers of certain peace officers and police officers

> Any peace officer, when acting pursuant to his special duties, or police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department **may take into custody any person who appears to be mentally ill and is conducting himself in a manner which is likely to result in serious harm to himself or others. "Likelihood to result in serious harm" shall mean (1) substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or (2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.** Such officer may direct the removal of such person or remove him to any hospital specified in subdivision (a) of section 9.39 or, pending his examination or admission to any such hospital, temporarily detain any such person in another safe and comfortable place, in which event, such officer shall immediately notify the director of community services or, if there be none, the health officer of the city or county of such action.

MHL § 9.41 (emphasis supplied).

Section 9.58 provides as follows:

§ 9.58 Transport for evaluation; powers of approved mobile crisis outreach teams.

(a) A physician or qualified mental health professional who is a member of an approved mobile crisis outreach team shall have the power to remove, or pursuant to subdivision (b) of this section, to **direct the removal of any person who appears to be mentally ill and is conducting themselves in a manner which is likely to result in serious harm to themselves or others,** to a hospital approved by the commissioner pursuant to subdivision (a) of section 9.39 or section 31.27 of this chapter or where the team physician or qualified mental health professional deems appropriate and where the person voluntarily agrees, to a crisis stabilization center specified in section 36.01 of this chapter.

At the launch of the so-called Subway Safety Program by Mayor Adams and Governor Hochul in February 2022, OMH Commissioner Ann Marie T. Sullivan and Chief Medical Officer Thomas Smith issued interpretive guidance setting forth the circumstances under which courts have determined that the MHL already permits "persons who appear to be mentally ill and who display an inability to meet basic living needs" to be mandated into emergency psychiatric assessments and emergency and involuntary inpatient psychiatric admissions (the "OMH Involuntary Removal Guidance").[21]

As discussed below, New York courts have addressed the probable cause standard that justifies mental hygiene "arrests" under § 9.41 as well as the due process standards that must be met to permit involuntary retention, admission, and treatment where a person has been deemed to be unable to meet basic needs by reason of mental illness. There is no reported caselaw that addresses whether probable cause is required for a clinically-directed MHL § 9.58 direction to law enforcement to effect a mental hygiene arrest. And, there is no reported caselaw that assesses whether inability to meet basic needs rises to the level of probable cause to justify a mental hygiene arrest under either MHL § 9.41 or MHL § 9.58.

Constitutional Considerations

In discussing involuntary confinement, the United States Supreme Court has determined that "a State cannot constitutionally confine, without more, a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975). The Court further directed that "[m]ere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty." *Id.* At 575. The Second Circuit has cautioned, in a case concerning the mental hygiene arrest of a woman for psychiatric evaluation, that evidence that the woman appeared irrational, annoyed, and very uncooperative, without more, was insufficient to infer that she was dangerous and, thus, establish probable cause for arrest. *Myers v. Patterson*, 819 F.3d 625, 632 (2d Cir. 2016).

Federal courts have long read constitutional guarantees of due process into the various provisions of MHL Article 9 as they relate to involuntary admission, retention and treatment. *See e.g.*

(b) **If the team physician or qualified mental health professional determines that it is necessary to effectuate transport, he or she shall direct peace officers, when acting pursuant to their special duties, or police officers, who are members of an authorized police department or force or of a sheriff's department, to take into custody and transport any persons identified in subdivision (a) of this section.** Upon the request of such physician or qualified mental health professional, an ambulance service, as defined in subdivision two of section three thousand one of the public health law, is authorized to transport any such persons.

MHL § 9.58 (emphasis supplied).

[21] *See* Interpretative Guidance for the Involuntary and Custodial Transportation of Individuals for Emergency Assessments and for Emergency and Involuntary Inpatient Psychiatric Admissions, Date: February 18, 2022, https://omh.ny.gov/omhweb/guidance/interpretative-guidance-involuntary-emergency-admissions.pdf.

As noted, this document was issued by OMH in connection with Governor Hochul's and Mayor Adams' joint plan to sweep away a variety of people sheltering in the New York City subway system. *See* Subway Safety Plan, https://www1.nyc.gov/assets/home/downloads/pdf/press-releases/2022/the-subway-safety-plan.pdf.

Project Release v. Prevost, 722 F.2d 960 (2d Cir. 1983). It is well settled that for involuntary removals under Section 9.41 of the MHL, "courts apply the same concepts of probable cause and objective reasonableness as in criminal cases to determine whether the confinement is privileged because the plaintiff's behavior was likely to result in serious harm." *Greenaway v. County of Nassau*, 97 F. Supp. 3d 225, 233 (E.D.N.Y. 2015). In doing so, courts treat involuntary removals as "the functional equivalent of [] arrest[s]," *Disability Advocates., Inc. v. McMahon*, 279 F. Supp. 2d 158, 168-69 (N.D.N.Y. 2003), *aff'd,* 124 F. App'x 674 (2d Cir. 2005).

Probable cause for a MHL § 9.41 mental hygiene arrest only "exists if there are reasonable grounds for believing that the person seized is dangerous to herself or to others." *Guan v. City of New York*, 2020 WL 6365201 (S.D.N.Y. Oct. 29, 2020), *aff'd on other grounds*, 37 F.4th 797 (2d Cir. 2022) (internal citation and quotation omitted); *Anthony v. City of New York*, 339 F.3d 129, 142 (2d Cir. 2003) (citation omitted).[22]

OMH Involuntary Removal Guidance

Although the OMH Involuntary Removal Guidance does not reference the standards requiring probable cause and danger to self or others that cabins mental hygiene arrests under MHL §§ 9.41 and 9.58, the OMH Involuntary Removals Guidance specifies that for purposes of a 9.41 mental hygiene arrest, "[l]ikelihood of serious harm includes: attempts/threats of suicide or self-injury; threats of physical harm to others; or other conduct demonstrating that the person is dangerous to him or herself, including a person's refusal or inability to meet his or her essential need for food, shelter, clothing or health care, **provided that such refusal or inability is likely to result in serious harm if there is no immediate hospitalization**" (emphasis added).[23] Whether inadvertent or intentional, this language is not repeated in the OMH Involuntary Removals Guidance relating to MHL § 9.58.

With respect to MHL § 9.41 mental hygiene arrests, the OMH Involuntary Removal Guidance relies on caselaw describing an individual's inability to meet their essential needs in the context of continued retention or involuntary admission of the person for psychiatric treatment (as opposed to mental hygiene arrests). It notes that in order to satisfy substantive due process requirements, "the continued confinement of an individual must be based upon a finding that the

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[22] As noted, there is no reported case law assessing probable cause for a removal directed pursuant to MHL § 9.58.

[23] OMH Involuntary Removals Guidance at 3 (quoting *Matter of Scopes v. Shah*, 59 A.D.2d 203, 398 N.Y.S.2d 911 (3d Dep't 1977)). In *Matter of Scopes*, the Appellate Division's Third Department ruled that in order to satisfy substantive due process requirements, "the continued confinement of an individual must be based upon a finding that the person to be committed poses a real and present threat of substantial harm to himself or others.") *See also Matter of Carl C.*, 126 A.D.2d 640 (2d Dept 1987) ("State must prove, by clear and convincing evidence, that the person is mentally ill and that he poses a substantial threat of physical harm to himself (resulting) from a refusal or inability to meet his essential needs for food, clothing or shelter"); *Boggs v. Health Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (1st Dept. 1987)(noting that the sole issue before the court is whether, upon clear and convincing evidence, "Ms. Boggs is so severely mentally ill that, unless she continues to receive hospital treatment, she is in danger of doing serious harm to herself"). In the *Boggs* case, the evidence before the court presented a combination of factors that led to the court's conclusion that there was justification for involuntary retention of Ms. Boggs in a psychiatric facility, i.e. Ms. Boggs was homeless and was allegedly living without sufficient clothing on a sidewalk grate in winter, running into traffic, making verbal threats to passersby, tearing up and urinating on money that passersby gave her, and covering herself in her own excrement.

person to be committed poses a real and present threat of substantial harm to himself or others, but that such a finding does not require proof of a recent overtly dangerous act."[24]

As Written, the NYC Mental Health Involuntary Removals Policy Deviates Significantly from the OMH Involuntary Removals Guidelines

The NYC Mental Health Involuntary Removals Policy, as written (and discussed by Mayor Adams) deviates significantly from the standard of proof set forth in caselaw and the OMH Involuntary Removals Guidance that establishes when the "inability to meet essential needs" (or the so-called "basic needs standard") rises to the level of "likely to result in serious harm."

The NYC Mental Health Involuntary Removals Policy notes that "case law does not provide extensive guidance regarding removals for mental health evaluations based on short interactions in the field" and then suggests that the following circumstances "could be reasonable indicia": "serious untreated physical injury, unawareness or delusional misapprehension of surroundings, or unawareness or delusional misapprehension of physical condition or health." These are vague, broad, and undefined standards untethered to caselaw or the OMH Involuntary Removals Guidelines directives. Moreover, these circumstances do not in fact incorporate the immediacy standard the OMH Involuntary Removals Guidelines require.[25]

The City's interpretation of the basic needs standard as set forth in the NYC Mental Health Involuntary Removals Policy, presents as patently insufficient to meet the OMH-cited caselaw establishing what constitutes danger to self-standard as measured by the incapacity to survive safely in the community. Given *O'Connor*, application of the basic needs standard absent sufficient indicia of dangerousness raises constitutional concerns. *See also Myers*, 819 F.3d at 632 (holding that a display of irrationality, annoyance, and a lack of cooperation was insufficient to imply dangerousness and to establish that the police acted with probable cause).

The NYC Mental Health Involuntary Removals Policy's attempt to establish a link between basic needs and conduct likely to result in serious harm is analogous to the police's unsuccessful attempt to establish a link between dangerousness and behaviors unrelated to harm in *Myers*. The mere fact that an unhoused person cannot, economically, procure housing and chooses the safety of the subway vs. the dangerousness of city congregate shelters does not constitute *per se* evidence of mental illness. Pretextual removals on this ground, as the NYC Mental Health

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[24] OMH Involuntary Removals Guidance at 2 (internal citation and quotation omitted).

[25] As you know, FINEST messages are urgent communications to the NYPD force as a whole. The attached FINEST message addresses the NYC Mental Health Involuntary Removals Policy and directs NYPD officers to conduct a mental hygiene arrest when the person appears mentally ill and incapable of meeting basic human needs to such an extent that the person is likely to suffer physical injury or serious harm **without immediate attention**" (emphasis supplied). The FINEST message also offers examples (without language of imminence of danger): "an incoherent person may be unable to assess and safely navigate their surroundings (e.g. avoiding oncoming traffic or subway tracks), may suffer from a serious untreated injury, or unable to seek out food, shelter or other things needed for survival" (emphasis supplied).

Unlike the NYC Mental Health Involuntary Removals Policy, the FINEST message both references OMH's standard of imminent harm and urgency and *O'Connor's* language with respect to survival. The FINEST message also notes that NYPD Legal Affairs is available to provide some level of support to officers in the field.

Involuntary Removals Policy directs, would be contrary to long established federal and state constitutional rights and norms.

3. The NYC Mental Health Involuntary Removals Policy Reflects and Will Exacerbate Bias against Unhoused People and People with Mental Illness and Will Disproportionately Burden People of Color

There is enormous bias reflected in statements accompanying the Administration's public discussion of the NYC Mental Health Involuntary Removals Policy – as well as statements concerning the various joint city and state initiatives to sweep New Yorkers, who are disproportionately people of color, who are unhoused or experiencing mental illness out of public sight and into institutional settings and forced treatment.

Stoking Bias

It is critically important that the Council focus their attention on the public justifications proffered for this initiative.

Mayor Adams has routinely noted that the administration has a "moral obligation" to connect severely mentally ill New Yorkers to appropriate care and housing. The NYCLU, and likely everyone the Council will hear from during this oversight hearing, agree completely with this unremarkable statement. Society's shared "moral obligation" derives in large part from the doctrine of *parens patriae*, a legal term referring to the power of the government to act on behalf of people who are unable to care for themselves.[26] Indeed, Article XVII of the New York State Constitution, the "Social Welfare" provision of the state constitution, makes manifest the government's inherent *parens patriae* power with its mandate that New York must provide 'aid, care and support of the needy."[27] Article XVII specifically includes those with mental illness and other disabilities.[28]

But the Adams administration, and the City's state partners, proffer a second enormously troubling and retrogressive rationale. This rationale repeats unjustified and stigmatizing language that relies upon pernicious stereotypes and exacerbates bias – that New Yorkers who are

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[26] The New York Court of Appeals explained the *parens patriae* doctrine in *Rivers v. Katz*, 67 N.Y.2d 485, 496-97 (N.Y. 1986) as follows: "There is no doubt that the State may have a compelling interest, under its *parens patriae* power, in providing care to its citizens who are unable to care for themselves because of mental illness (*Addington v Texas*, 441 U.S. 418, 426 [1979]). For the State to invoke this interest, 'the individual himself must be incapable of making a competent decision concerning treatment on his own. Otherwise, the very justification for the state's purported exercise of its *parens patriae* power — its citizen's inability to care for himself [...] would be missing. Therefore, *the sine qua non* for the state's use of its *parens patriae* power [...] is a determination that the individual [...] lacks the capacity to decide for himself' (*Rogers v Okin*, 634 F.2d 650, 657 [1980]; *see also, Matter of K.K.B.*,609 P.2d 747, 750 [Okla. 1980]. **Such a determination is uniquely a judicial, not a medical function** (*see, Rogers v. Commissioner of Dept. of Mental Health*, 390 Mass. 489 [1983]; *Matter of Roe*,383 Mass. 415 [1980]" (emphasis supplied).

[27] NY Const art XVII § 1. The Social Welfare provision of the state constitution arose from the crash of the stock market in 1929 and the ensuing depression that wrought unprecedented and widespread devastation for the lives of New Yorkers, and countless millions, across the country. Facing an unprecedent homelessness crisis then, the New York State Constitution was amended to include the social welfare mandate.

[28] NY Const art XVII § 4.

unhoused and/or living with mental health challenges *per se* constitute a direct threat to the personal safety of others.

That a person is unhoused or living with mental health challenges is not indicative of dangerousness to others. Nor is an inability to meet one's own basic needs indicative of dangerousness to others.[29]

Yet the mayor's statements at the November press conference directly draw the line between mental illness and the always present likelihood of violent acts directed by that person towards others:

> There's nothing dignified about using a corner of a tent as a restroom or having month-old food sitting there or talking to yourself, being delusional, or waiting until you carry out a dangerous act before we respond. That is just so irresponsible that **we know that this person is about to probably go off the edge and harm someone** but we're going to wait until it happened.[30]

The City's Subway Safety Plan prioritizes the perceptions of the public who have ingrained fear of unhoused people, people with mental illness and, inevitably, people of color:

> [O]ur subways must be safe and feel safe for every person who enters them . . . . Our city's prosperity depends on everyone feeling confident and secure when they enter a station.[31]

The joint City and State report *Making New York Work for Everyone* specifically offers up the Subway Safety Plan, the ongoing New York City homeless sweeps initiative and the NYC

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[29] Individuals who are homeless have an increased risk of victimization and violence. The prevalence of violence victimization in the homeless population has been estimated to range from 14% to 21% and approximately one-third report having witnessed a physical attack on another person who was. This rate of violence is highly disparate when compared to the general population in which only 2% report experiencing a violent crime. In addition, research has demonstrated that some subpopulations of homeless individuals are at even increased risk of experiencing violence. For instance, those who experience longer bouts of homelessness have increased risk of victimization. Those who have been previously turned away from a shelter or reported committing a crime since becoming homeless are also significantly more likely to experience victimization. *See e.g. Violence and Victims: Exploring the Experiences of Violence Among Individuals Who Are Homeless Using a Consumer-Led Approach, Violence and Victims*, Volume 29, Number 1, 2014, https://nhchc.org/wp-content/uploads/2019/08/vv-29-1_ptr_a8_122-136.pdf.

People with mental illness are also no more violent than the general population and, are in fact, actually 12 times more likely to be victims of violent crime opposed to perpetrators. *See The Population Impact of Severe Mental Illness on Violent Crime*, Seena Fazel, M.B.Ch.B., M.R.C.Psych., M.D.; Martin Grann, C.Psych., Ph.D., Am J Psychiatry 2006;163:1397-1403, http://ajp.psychiatryonline.org/article.aspx?articleid=96905. Despite popular perceptions and fears, empirical data connecting even severe mental illness with an increased risk of perpetrating violence towards others is mixed, and an appropriate assessment of dangerousness is necessarily highly individualized. *See, e.g., Violence and Mental Illness: What is the True Story?* Varshney M, Mahapatra A, Krishnan V, et al. , J Epidemiology & Community Health 2016; 70:223-225, https://jech.bmj.com/content/70/3/223.

[30] "Address on the Mental Health Crisis in New York City," https://www.nyc.gov/office-of-the-mayor/news/871-22/transcript-mayor-eric-adams-delivers-address-mental-health-crisis-new-york-city-holds.

[31] Subway Safety Plan at 4, https://www1.nyc.gov/assets/home/downloads/pdf/press-releases/2022/the-subway-safety-plan.pdf.

Mental Health Involuntary Removals Policy as the most immediate and successful solutions to the alleged dangers of criminally violence behavior presented by New Yorkers who are disproportionately people of color, who are unhoused or experiencing mental illness:

> Concerns about safety and quality of life can stymie economic prosperity in terms of investment, revenue, and overall economic activity. We must acknowledge that many residents, commuters, and business owners have been increasingly concerned for their safety and that of their employees as they move around the city[32] [...] as part of the [NYC Mental Health Involuntary Removals Policy] plan, the Mayor issued a directive to outreach workers, City-operated hospitals, and first responders clarifying that they have the legal authority to provide care to New Yorkers when severe mental illness prevents them from meeting their own basic human needs to the extent that they are a danger to themselves **or others** (emphasis added).[33]

Even Governor Hochul, announcing the proposed 2023-2024 budget package largely directed at funding New York City's mental health services, intentionally conflates public discomfort with actual danger, describing "a public safety crisis" stemming from underfunding of mental health services and pointing to the public feeling "anxious" about encountering people with mental health conditions while on the subway.

> Right now, nearly 3,200 New Yorkers struggling with severe mental illness or addiction are living on the street and subways. At the same time, we have insufficient levels of inpatient psychiatric beds and outpatient services [...] We have underinvested in mental health care for so long, and allowed the situation to become so dire, that it has become a public safety crisis, as well [...] New Yorkers are feeling anxious on the subway when they encounter people who struggle with mental illness and need help.[34]

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[32] *Making New York Work for Everyone*, December 2022, at pg. 42, https://edc.nyc/sites/default/files/2022-12/New-NY-Action-Plan-Making_New_York_Work_for_Everyone.pdf.

We note that the *Making New York Work for Everyone* report appears to be the culmination of months of collaboration of a panel of "top business and community leaders under the stewardship of two former Deputy Mayors." *See Making New York Work for Everyone* at 4. Regrettably this constellation of "civil leaders and industry experts" included NO people with lived experiences, NO experts in mental health treatment or leaders of disability advocacy organizations, and NO experts in housing for people with disabilities or leaders of housing and homeless advocacy organizations.

The disability justice community has long advocated "nothing about us without us," calling for policy making that ensures the full and direct participation of members of the group/s affected by that policy. Regrettably, City and state leaders routinely show scant commitment to inclusive decision relating to people with disabilities, including people with mental illness, and people who are unhoused, much less New Yorkers from impacted communities of color.

[33] *Making New York Work for Everyone* at 44.

[34] Destra, Shantel, "Lawmakers welcome Hochul's $1 billion to address mental health," City & State NY, Jan. 11, 2023. https://www.cityandstateny.com/policy/2023/01/lawmakers-welcome-hochuls-1-billion-address-mental-health/381708/.

This type of verbiage from Mayor Adams and his state and local partners is extraordinarily harmful and have the effect of perpetuating grossly retrospective bias against New Yorkers living with mental illness and New Yorkers who are unhoused.[35]

The NYC Mental Health Involuntary Removals Policy Also Implicates
Disability and Other Operative Anti-Discrimination Laws and Caselaw

Beyond the constitutional concerns occasioned by the NYC Mental Health Involuntary Removals Policy, City, State, and Federal statutes and interpretive caselaw prohibit discrimination on a variety of bases, including disability (which itself includes mental illness and substance use disorders), and require the City and other government entities to provide reasonable accommodations to people with disabilities. The NYC Mental Health Involuntary Removals Policy, as written, appears to violate this well-developed anti-discrimination rights regimen.[36]

For example, the NYC Mental Health Involuntary Removals Policy would appear to deny people access to public spaces such as the subway and the streets, based on their actual or perceived mental illness, in violation of the Americans with Disabilities Act (ADA).[37]

To the extent that the NYC Mental Health Involuntary Removals Policy would sweep New Yorkers into institutional settings and forced treatment, the NYC Mental Health Involuntary Removals Policy would appear also to violate the ADA "integration mandate" established by *Olmstead v. L.C.*, 527 U.S. 581 (1999). In *Olmstead*, the Supreme Court held that unnecessary

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[35] We direct the Council's attention to the Making New York Work for Everyone report, which was the culmination of months of collaboration of a panel of "top business and community leaders under the stewardship of two former Deputy Mayors." *See* "Making New York Work for Everyone" at 4. Regrettably this constellation of "civil leaders and industry experts" included NO people with lived experiences, NO experts in mental health treatment or leaders of disability advocacy organizations, and NO experts in housing for people with disabilities or leaders of housing and homeless advocacy organizations.

The disability justice community has long espoused the demand: "nothing about us without us," calling for no policy making by any entity without the full and direct participation of members of the group/s affected by that policy. Yet City and State leaders routinely show scant commitment to inclusive decision relating to people with disabilities, including people with mental illness, and people who are unhoused.

[36] Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132, provides: "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." The City's Human Rights Law further provides: "it is an unlawful discriminatory practice for any person prohibited by the provisions of this section from discriminating on the basis of disability not to provide a reasonable accommodation to enable a person with a disability to . . . enjoy the right or rights in question provided that the disability is known or should have been known by the covered entity." N.Y.C. Admin. Code § 8-107(15)(a).

[37] Of course, the ADA explicitly does not require an entity to include an individual who presents a "direct threat" meaning "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services." 42 U.S.C. § 12182(3). But, for all of the reasons set forth above, the NYC Mental Health Involuntary Removals Policy would appear to cover a significant range of situations that cannot be categorized as falling within this particular provision of the ADA.

institutionalization of people with disabilities constitutes discrimination under the ADA.[38] The ADA's integration mandate "requires that individuals with disabilities receive services in the most integrated setting appropriate to their needs."[39] A variety of NYS agencies, including the Office for People with Developmental Disabilities[40] as well as OMH[41] have acknowledged that this mandate necessitates a shift in New York's state mental health services towards greater community-based services.

To the extent that the NYC Mental Health Involuntary Removals Policy would sweep New Yorkers, who are disproportionately people of color, who are unhoused or experiencing mental illness, out of public sight and into institutional settings and forced treatment, this initiative is the latest of the Mayor's initiatives that burdens New Yorker's so-called "right to remain" in the public domain, as explained by the Supreme Court decades ago in *City of Chicago v. Morales*, 527 U.S. 41, 53–54 (1999). In *Morales*, the Supreme Court held that "the freedom to loiter for innocent purposes is part of the 'liberty' protected by the Due Process Clause of the Fourteenth Amendment.... Indeed, it is apparent that an individual's decision to remain in a public place of his choice is as much a part of his liberty as the freedom of movement inside frontiers that is a part of our heritage." (plurality opinion) (emphasis added) (internal quotation marks and citations omitted)). to endanger other constitutional freedoms, *see, e.g., Jones v. City of Los Angeles*, 444

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[38] It is important to note that the plaintiffs in *Olmstead* themselves had cycled in and out of psychiatric hospitalization, in large part due to the absence of appropriate supports and services in community-based settings. The Supreme Court stated in *Olmstead* that "unjustified institutional isolation of persons with disabilities is a form of discrimination" in part because "[i]n order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice." *Olmstead.*, 527 U.S. at 600-601.

[39] *See Serving People with Disabilities in the Most Integrated Setting: Community Living and Olmstead,* U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR), https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html.

[40] The Council may know that the NYCLU has long led the *Willowbrook* case, a landmark class-action litigation on behalf of people with intellectual disabilities initiated in 1972, that was in the vanguard of the civil rights movement for people with disabilities. Well before the Olmstead decision in 2009, New York State recognized the right of people with disabilities in the *Willowbrook* case to be afforded the "least restrictive and most normal living conditions possible." *See NYSARC et al, v. NYS, Parisi et al. v. NYS et al.,* 72 Civ. 356, 357 (U.S. District Court for the Eastern District of New York)(RJD)..

[41] *See e.g.* New York State Home and Community-Based Services Settings ("HCBS") Transition Plan (2018) at pg. 195, https://www.health.ny.gov/health_care/medicaid/redesign/hcbs/docs/2018-05-18_hcbs_final_rule.pdf. For example, New York's HCBS Transition Plan notes the pressing need for New York's mental health system to come into compliance with *Olmstead* and the ADA integration mandate:

> The legal system's expansion of civil rights to include people with mental illness, as part of Olmstead Legislation and Americans with Disabilities Act, has begun to move policy from the concept of least restrictive setting to full community inclusion. However, New York currently exceeds both the national average inpatient utilization rate at state-operated Psychiatric Centers (PCs), and per capita inpatient census levels at state-operated PCs in other urban states and all Mid-Atlantic States [...] OMH is in the process of creating the mental health system that New York needs in the 21st Century—a system focused on prevention, early identification and intervention, and evidence-based clinical services and recovery supports. OMH is rebalancing the agency's institutional resources to further develop and enhance community-based mental health services which are also consistent with the Americans with Disabilities Act (ADA). The US Supreme Court's 1999 Olmstead decision held that the ADA mandates that the State's services, programs, and activities for people with disabilities must be administered in the most integrated setting appropriate to a person's needs.

F.3d 1118, 1120 (9th Cir.2006) (striking down as a violation of the Eight Amendment's bar against punishing status rather than conduct a city ordinance that states that "no person shall sit, lie or sleep in or upon any street, sidewalk or public way").

The New York City Human Rights Law also contains a strong prohibition of so-called bias-based policing.[42] "Homeless sweeps" by the City including move along orders, property seizure and destruction, and arrest or threats of arrest, all to present forms of prohibited bias-based policing directed at New Yorkers on the basis of their actual or perceived status as persons with disabilities, persons who are unhoused and, of course, persons of other protected classes.[43] To the extent that the NYC Mental Health Involuntary Removals Policy would sweep New Yorkers, who are disproportionately people of color, who are unhoused or experiencing mental illness, out of public sight and into institutional settings and forced treatment, the NYC Mental Health Involuntary Removals Policy would violate the bias-based policing provisions of the Human Rights Law.

Disproportionate Effects on Communities of Color

The NYC Mental Health Involuntary Removals Policy also implicates the City's obligations to refrain from engaging in practices that have disparate effect on people of color. Data suggests policies like the NYC Mental Health Involuntary Removals Policy are likely to disproportionately impact Black and brown New Yorkers.

It is well documented that Black and brown people with disabilities are overrepresented in the population of individuals experiencing homelessness, and so are more likely to be involuntarily hospitalized under this initiative.[44] Black New Yorkers already make up 44% of the people currently receiving court-mandated treatment under one state law, though they are less than a quarter of the city's population. In New York City, 44% of current assisted outpatient treatment (AOT) recipients are Black and 32% are Latinx.[45] The OMH data suggests that Black

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[42] *See* NYC Admin Code 14-151. That section prohibits "bias-based profiling" defined as "an act of a member of the force of the police department or other law enforcement officer that relies on actual or perceived race, national origin, color, creed, age, immigration or citizenship status, gender, sexual orientation, disability, or housing status as the determinative factor in initiating law enforcement action against an individual, rather than an individual's behavior or other information or circumstances that links a person or persons to suspected unlawful activity."

[43] The Council may be aware that the New York City Human Rights Commission issued a "Notice of Probable Cause Determination and of Intention to Proceed to Public Hearing" in June 2020 relating to a challenge the NYCLU brought to the NYPD's targeted homeless sweeps activity in the 125th Street corridor adjacent to the MetroNorth Station. *See Picture The Homeless et al. v NYPD,* M-I-J-17-08068 ("Specifically, there is Probable Cause that Respondent [NYPD] has engaged in an unlawful discriminatory practice of bias-based profiling based on the actual or perceived housing status of Complainants [and other] members of the public").

[44] Basic Facts about Homelessness, Coalition for the Homeless, updated December 2022, https://www.coalitionforthehomeless.org/basic-facts-about-homelessness-new-york-city/. *See also* Stacy M. Brown, *Blacks Hit Hardest as NYC's Homeless Population Grows Amid Mental Health Crisis* (Mar. 23, 2022), https://www.washingtoninformer.com/blacks-hit-hardest-as-nycs-homeless-population-grows-amid-mental-health-crisis/.

[45] *See e.g.* NYS Office of Mental Health AOT/Kendra's Law Portal Page, https://my.omh.ny.gov/analytics/saw.dll?dashboard. *See also* Ethan Geringer-Sameth, *What's Behind the Increased Use of Kendra's Law in New York City?* , Gotham Gazette, September 27, 2022, https://www.gothamgazette.com/state/11599-increase-kendras-law-new-york-city?utm_source=The+Marshall+Project+Newsletter&utm_campaign=703deaa159-

and brown New Yorkers are, inevitably, much more likely to be subjected to forced removals from public spaces than white New Yorkers.

4. The Council must Ensure that this Administration Provides Robust and Complete Data concerning the NYC Mental Health Involuntary Removals Policy

As with many of this Administration's completely immoral initiatives directed at people who are unhoused who are, more often than not, people with disabilities, there has been a complete lack of transparency, clear processes, and failure of data collection and reporting with respect to the NYC Mental Health Involuntary Removals Policy. Information concerning this troubling initiative has been released only via press conference and via highly controlled and selective disclosure to chosen media outlets.

We urge that the Council insist on ongoing and frequent data reporting and detail concerning the execution of the NYC Mental Health Involuntary Removals Policy. First off, of course, the Council must understand the Administration's criteria for the identification of individuals to evaluate for transport under MHL § 9.41 or § 9.58 under the NYC Mental Health Involuntary Removals Policy. Once that information is made available, we suggest that the list of data points reported by the Administration include, but not be limited to, the following areas. Further, for each category, the demographic information of the impacted individuals should be provided.

- The number of individuals identified for evaluation for potential transport under MHL § 9.41 or § 9.58 under the NYC Mental Health Involuntary Removals Policy since the initiative was announced, or went live if a different date
- The number of encounters that have not resulted in transport
- The number of encounters that have resulted in connection to housing/other services
- The number of willing transports that have occurred
- The number of involuntary transports for assessment/evaluation that have occurred
- Identification of the facilities to which have individuals been transported for assessment
    - Including how many individuals have been transported to each identified facility[46]
- The number of individuals who have had actual Article 9 status conferred on them as a result of the transport for evaluation[47]
- The number of individuals who have been brought in and detained in a CPEP or other psychiatric setting for up to 72 hours but who have been released at or before the 72 hour mark
- The lengths of stay for individuals who are brought in for observation and assessment:
    i. before they are assessed;

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[46] The original directive indicates that EMT must "transport the individual to the closest appropriate hospital" – what does that mean ? Are these CPEPs or other OMH certified settings, H=H non-CPEP/OMH certified settings, any medical hospital.

[47] "Status" means being admitted under the Article 9 provisions of the MHL, i.e. the provisions of MHL actually do not become operative with various rights conferred on the person, including having access to counsel from the Mental Hygiene Legal Service and the right to actual discharge planning for connection to appropriate community services under MHL § 29.15

ii. before they are admitted;
iii. before they are released or discharged.

- The number of individuals who have been subjected to involuntary treatment while they are awaiting or under observation and assessment, including involuntary medication and/or restraint or seclusion
- The number of individuals who have been admitted for medical/clinical services but not mental health services [ie open wounds/other medical conditions – diabetes, cardio, substance/detox]
- The number of individuals who have had discharge planning accomplished for them as a result of the NYC Mental Health Involuntary Removals Policy
- The number of individuals who cannot be discharged because discharge planning and/or connection to appropriate community-based services cannot be accomplished
- The number of individuals who have had a Kendra's law order petition filed against them
- What kind of record keeping and data tracking is NYC, including the NYC Well apparatus, conducting with respect to all individuals who are being brought in for assessment and observation under the NYC Mental Health Involuntary Removals Policy

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Comments on Int. 0273-2022 and Int. 0706-2022

We offer brief comments on the two pieces of legislation that are on the hearing agenda.

Int. 273 would require that NYPD provide officers with training related to recognizing and interacting with individuals with autism spectrum disorder. Such training would include: (i) enhancing awareness and a practical understanding of autism spectrum disorder; (ii) development of the interpersonal skills to safely respond to emergencies involving someone with autism spectrum disorder; and (iii) instruction on interview and investigative techniques to utilize in cases involving individuals with autism spectrum disorder.

This bill, as well meaning as it is, is targeted only at NYPD training as it relates to autism spectrum disorder ("ASD").[48] ASD is only one specific type of developmental disability, which includes intellectual disabilities, cerebral palsy, Down syndrome, autism spectrum disorders, Prader-Willi syndrome and other neurological and cognitive impairments.

The bill leaves unprotected a large number of New Yorkers with developmental disabilities, other than ASD, whose interactions with law enforcement are potentially as equally problematic and dangerous. The bill also fails to consider the broad range of New Yorkers with disabilities, including those who are deaf/limited hearing, mental illness, substance, diabetic shock, and age-

[48] Int. 273 defines the "term 'autism' [as] a range of conditions characterized by challenges with social skills, repetitive behaviors, speech and nonverbal communication, as well as other unique conditions which may be caused by different combinations of genetic and environmental influences. This definition is both overly inclusive and underly inclusive; it does not comport with generally understood definitions of ASD, as defined in the American Psychiatric Association fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and, as a result, may lead to enormous confusion in any training modules that may be developed. *See* ASD as defined in the DSM-5, https://www.autismspeaks.org/autism-diagnosis-criteria-dsm-5.

related dementia, as well as those New Yorkers with limited English proficiency at risk of grievous harm occurring due to their interactions with law enforcement.

With respect to the training curriculum, the bill also vests the NYPD with complete discretion with respect to the training to be conducted. Moreover the bill contemplates that any training may simply be one-time training module offered during the officer's time at the NYPD Academy.[49]

We applaud the Council for its efforts to ensure that people with ASD do not have negative, or fatal, experiences with law enforcement. But there is much more work that the Council could do to ensure that NYPD has meaningful and regular training sessions for its personnel concerning disabilities and clear guidelines for interacting with people with disabilities. Organizations and individuals representing a wide range of disciplines and perspectives and with a strong interest in improving law enforcement encounters with people with disabilities should be convened to work together in one or more groups to help guide NYPD's training and implementation efforts.[50]

Int. 706 would require the Mayor's Office of Community Mental Health ("MOCMH") to create an online portal and a written resource guide of available mental health services. The portal and guide would organize services by population and then by type of service. The information is intended to be available in the citywide languages as designated in NYC Admin. Code § 23-1101. The bill would also require the Office to conduct outreach on the portal and the guide and ensure the portal is secure and confidential to protect the privacy of individuals accessing the portal.

We would ask that the Council consider ensuring that MOCMH is able to reach all New Yorkers in analogue form of the catalogue resources because we still have a massive digital divide in this city.[51] Moreover, we ask that the Council consider ensuring that in assembling the required information about mental health services available in the City, MOCMH is mandated to receive inputs and participate in meaningful engagement with community-based organizations. MOCMH is an interagency mental health council comprised almost entirely of city employees. Planning

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[49] Int. 273 directed that the NYPD "shall train patrol officers in recognizing and responding to individuals with autism as part of their academy training. The training shall be sensitive to a wide variation in challenges and strengths possessed by each individual with autism."

[50] The United States Department of Justice Bureau of Justice Assistance offers many resources that would be useful for the Council to review. *See e.g. Police-Mental Health Collaboration (PMHC) Toolkit*, https://bja.ojp.gov/program/pmhc/learning/essential-elements-pmhc-programs/1-collaborative-planning-and-implementation. The PMHC Toolkit provides resources for law enforcement agencies to partner with service providers, advocates, and individuals with mental illness and/or intellectual and developmental disabilities (I/DD). The goal of these partnerships is to ensure the safety of all, to respond effectively, and to improve access to services and supports for people with mental illness and I/DD.

[51] The bill appears to suggest that only certain people would receive a paper copy of the resource guide. As the Council is well aware, predictably, the brunt of the digital divide falls on particular communities. The Coucil has reported, for example, that the most impacted communities are home to individuals who disproportionately live at the intersection of poverty and structural racism. About a quarter of New York City households lack a broadband subscription at home and the percentage is even higher for Black, Hispanic, low-income, and senior households. For some community districts — many in the Bronx and high-poverty areas — over 40% of households do not have high-speed broadband service. Between 11 and 13 percent of NYC DOE students in each borough lack access to adequate internet at home during remote learning. *See, e.g., Broadband and Equal Access to the Internet in New York City,* https://council.nyc.gov/data/internet-access/.

appears to originate in a top down fashion conducted entirely by city employees who are not likely to have any meaningful connection to the impacted neighborhoods and the people most in need. The communities disproportionately impacted by mental health concerns are integral to the development, and distribution, of services resources.

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In closing, the NYCLU thanks the Committees for the opportunity to provide testimony on these critical issues. We stand ready to working with the members of the Committees conducting this oversight hearing, and all appropriate partners, to advance meaningful policy changes that will improve the lives of New Yorkers confronting housing, mental health and/or substance use challenges.

NYLAG
New York Legal Assistance Group

Testimony by the New York Legal Assistance Group on

Mental Health, Involuntary Removals and Mayor Adams' Recently Announced Plan Before the New York City Council's Committee on Mental Health, Disabilities & Addiction, Committee on Public Safety, Committee on Hospitals and the Committee on Fire and Emergency Management

February 6, 2023

Chairs Lee, Hanks, Narcisse, and Ariola, Council Members, and staff, good morning and thank you for the opportunity to speak to the New York City Council on mental health, involuntary removals and Mayor Adams' recently announced plan. My name is Deborah Berkman, and I am the Supervising Attorney of the Shelter Advocacy Initiative and the Public Assistance and SNAP Practice in the Public Benefits Unit at the New York Legal Assistance Group ("NYLAG").

NYLAG uses the power of the law to help New Yorkers experiencing poverty or in crisis combat economic, racial, and social injustices. We address emerging and urgent needs with comprehensive, free civil legal services, financial empowerment, impact litigation, policy advocacy, and community partnerships. We aim to disrupt systemic racism by serving clients, whose legal and financial crises are often rooted in racial inequality.

The Shelter Advocacy Initiative at NYLAG provides legal services and advocacy to low-income people in and trying to access public shelter in New York City, particularly the Department of Homeless Services ("DHS") shelter system. We work

to ensure that every New Yorker has a safe place to sleep by offering legal advice and representation throughout each step of the shelter application process. We also assist and advocate for clients who are already in shelter as they navigate the transfer process, seek adequate facility conditions and resources for their needs, and we offer representation at fair hearings.

I have worked with numerous people experiencing street homelessness who live in fear of being incarcerated because they are impoverished, and I have represented several individuals who have been subject to involuntary removal from the street. Based on my experiences working with them, I appreciate the opportunity to offer the following comments.

I. The Mayor's Initiative Does Not Meet the Standards for Involuntary Removal and Instead Criminalizes Poverty

Simply put, sleeping outside does not meet the standard for involuntary removal under Mental Hygiene Law Section 9.41. That section authorizes an individual to be taken into custody, for the purpose of a psychiatric evaluation if that person:

> appears to be mentally ill and is conducting himself in a manner which is likely to result in serious harm to himself or others. "Likelihood to result in serious harm" shall mean (1) substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or (2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.[1]

New York City (and New York State) has somehow determined that "likely to result in serious harm to himself or others" is synonymous with "a person who appears to be

[1] McKinney's Mental Hygiene Law § 9.41

mentally ill and displays an inability to meet basic living needs, even when no recent dangerous act has been observed."[2] The City's guidance goes on to state that if "the circumstances support an objectively reasonable basis to conclude that the person appears to have a mental illness and cannot support their basic human needs to an extent that causes them harm, they may be removed for an evaluation."[3] Even more egregious, in the New York Police Department's (NYPD's) communication to its officers, it uses as an example of someone appropriate for involuntary removal someone who is not able to "seek out food, shelter and other things needed for survival."[4] The communication goes on to state that "these circumstances are likely to lead a person to serious harm."[5]

This analysis is a gross misreading of the text of Mental Hygiene Law Section 9.41, which specifically states that examples of "[l]ikelihood to result in serious harm" include threats of or attempts at suicide or homicidal or other violent behavior.[6] These examples refer to spoken threats of violent physical harm.

The policy set forth by the City and State could not be further from the standard of spoken threats of violent physical harm. First, the City asks the NYPD officers to determine the presence mental illness, which can span a range of conditions. It appears that no guidance is provided on how to determine whether a person has a mental illness. Next, the policy cites as evidence of a person "conducting himself in a

[2] https://www.nyc.gov/assets/home/downloads/pdf/press-releases/2022/Mental-Health-Involuntary-Removals.pdf
[3] Id.
[4] NYPD Finest Message 42286935, dated 12/6/2022
[5] Id.
[6] McKinney's Mental Hygiene Law § 9.41

manner which is likely to result in serious harm to himself" the circumstance of that person being unable to afford food and shelter. This is nothing short of a declaration that extreme poverty constitutes grounds for involuntary removal. And Mental Hygiene Law Section 9.41 makes no mention of poverty being a factor to consider when determining whether involuntary removal is appropriate.

Sleeping outside is not evidence of mental illness; it is a function of lack of resources and fear of congregate shelter. There is a common misconception that people who are experiencing street homelessness does not want to sleep inside. This is most often not the case. Most of DHS' single adult shelter system consists of congregate shelters which can have up to 100 people in a single dorm or room. The majority of my clients experiencing street homelessness have tried to stay in DHS' congregate single adult shelters and have not been able to remain there due to assault and trauma they endured by other residents while there. Quite simply, they are too scared to go back.

Other clients cite different obstacles to remaining in single adult shelter. I have had numerous clients repeatedly lose their beds due to missing curfew and having no choice other than to sleep outside or to be bussed to an unknown location. Many of my clients report that residents are prohibited from bringing outside food into the shelter. As a result, almost all single adult shelter residents report being perpetually hungry because meals in shelter are served during a narrow timeframe, in limited supply, and the portions and quality of the food are inadequate. Additionally, many

residents with health issues and disabilities need to eat between meals or when taking medications.

Clients are also prevented from staying in single adult shelter because of the intense policing of shelters and the aggression of shelter staff and security towards residents. I have many clients who are forced into street homelessness because of negative interactions with shelter staff, who have been known to verbally and physically abuse clients. Additionally, multiple clients have reported to me being beaten by DHS police.

Even purportedly "accessible" shelters are in fact inaccessible for clients with disabilities. Clients who use wheelchairs or other assistive devices often report broken elevators and facilities that are impossible to navigate in a wheelchair, even when the shelters are labeled "accessible." Clients with mental health disabilities report that they are rarely, if ever, accommodated. Lastly, congregate single adult shelter is often impossible for homeless transgender or gender non-binary clients who experience extreme harassment from staff and other residents. All of these factors contribute to single adult street homelessness and are not symptoms of mental illness.

The City and State's plan strips the rights of people living with mental illness and poverty and will do little to help people transition inside.

II. This Initiative Will Not Be Effective at Mitigating Street Homelessness

Recent plans and policies have prioritized removing the visibility of people experiencing street homelessness but have not been effective to actually help people

transition inside. For example, over the first four months of enactment of the "Subway Safety Plan", just 0.3 percent of 83,591 underground "engagements" by police and outreach teams led to a person entering shelter.[7] Then, between March 18th and the end of October 2022, the City cleared 3,198 "homeless encampments" from streets in a wave of violent "sweeps" in attempt to get the people staying there to enter shelter.[8] However, only 5% of these people entered the shelter system as a result.[9]

Ordering the hospitalization of people deemed too mentally ill to care for themselves, even if they do not pose a threat, is not only cruel and inhumane, but will also undoubtably be similarly ineffective. New York does not have enough psychiatric beds to accommodate those in need.[10] In fact, New York City has a chronic bed shortage, and hospitals consistently struggle to accommodate new psychiatric emergency patients.[11] There is simply nowhere for more psychiatric inpatients to go. As a result, people are consistently turned away.

In recent months, two of my clients have been involuntarily removed from their sleeping place. The first of these clients, Mr. V., was escorted to an ambulance purportedly because he needed help. On the ride to the hospital, Mr. V. conversed with the EMTs, and once the ambulance reached the hospital, the EMTs released him, as they believed he was not a danger to himself or others. He then returned to his

[7] Id.
[8] https://gothamist.com/news/mayor-adams-homeless-encampment-sweeps-result-in-just-115-people-entering-nyc-shelters
[9] Id.
[10] https://www.nytimes.com/2022/11/30/nyregion/mental-health-plan-eric-adams.html
[11] Id.

usual spot. The second client, Mr. L. was the victim of a sweep and lost all of his belongings as a result. During the sweep, he was escorted to the hospital and remained there for two days, after which he was released. At that point, Mr. L returned to his usual spot.

Unless people experiencing homelessness are involuntarily confined indefinitely, this program, as with his other initiatives, will do little to reduce street homeless.

III. The City Should Create Safe Small-Room Shelters In Order to Mitigate Street Homelessness

In order to truly mitigate street homelessness, the City must create shelters with small rooms that are more accessible to people experiencing street homelessness. Most of my clients who are experiencing homelessness would come inside if they were offered such a placement, called a safe-haven or stabilization placement. Safe-haven and stabilization sites have more private and semi-private rooms and have fewer harsh rules and regulations than the single adult shelter system. Due to a lack of capacity, DHS has created a complex eligibility structure for safe-haven or stabilization placements, mandating that, to be eligible, people who are experiencing street homelessness must be spotted by the same outreach team numerous times. Only after meeting this requirement, the person experiencing homelessness is added to a waitlist for a stabilization or safe-haven placement to become available.

Additionally, my clients report that if they have presented at their assigned DHS single adult system shelter even one time over the past year, then street outreach teams have been instructed that such clients are precluded from a safe-

haven or stabilization placement, regardless of the traumatic experiences or lack of accessibility that may have forced clients to abandon their previous assignment. This tracks with the DHS system of shelter assignment as single adults are assigned to a shelter for a calendar year after the last time they entered that shelter, even if they have not been back in months. This policy discourages clients from trying to return to their previously assigned shelter because they (correctly) believe this will preclude them getting a safe-haven or stabilization placement. DHS should not punish clients who attempt to stay in shelter and are unsuccessful by precluding them from a safe-haven or stabilization placement.

DHS must significantly increase safe-haven and stabilization bed capacity to meet the needs of those experiencing street homelessness.

We thank the Council for the work it has done to facilitate services for vulnerable New Yorkers, and for taking this opportunity to continue to improve the conditions for our clients. We hope we can continue to be a resource for you going forward.

Respectfully submitted,

New York Legal Assistance Group

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Testimony of

Ruth Lowenkron, Disability Justice Director

on behalf of

New York Lawyers for the Public Interest

before the

Council of the City of New York

Committee on Mental Health, Disabilities, and Addiction

regarding

Oversight – Mental Health Involuntary Removals and

Mayor Adams' Recently Announced Plan

February 6, 2023

Good morning. My name is Ruth Lowenkron and I am the Director of the Disability Justice Program at New York Lawyers for the Public Interest (NYLPI). Thank you for the opportunity to present testimony today regarding involuntary removals of individuals perceived to have mental illness diagnoses and Mayor Adams' Involuntary Removal Plan which he announced on November 29, 2022.

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

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

The Policy is both illegal and immoral.

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

Details on the Involuntary Removal Policy are scarce, but Mayor Adams' statements, as well as the City's November 28, 2022 press release, entitled "Mental Health Involuntary Removals," make clear that city agencies plan to aggressively institute involuntary removals by police officers who have little to no expertise in dealing with individuals with mental disabilities and who will be required to determine whether an individual should be forcefully detained against their will. The

examples cited by Mayor Adams at his press conference illustrate how difficult it will be for police officers to make these sorts of determinations and how likely it is that the rights of New Yorkers will be violated by the Involuntary Removal Policy. Mayor Adams' example of "the shadow boxer on the street corner in Midtown, mumbling to himself as he jabs at an invisible adversary," does not describe someone who is unable to care for their basic needs, let alone describe someone who meets the standard of serious danger to themselves or others. The City's Involuntary Removal Policy also contains no information about how an officer would even go about determining whether such shadow boxers are unable to take care of their basic needs or are merely exercising.

Notably, even the NYPD's union has raised questions about how the police are to implement the Involuntary Removal Policy, noting that the new policy will put a strain on the "understaffed, overworked and underpaid" NYPD officers[1]. In addition, it has been reported that the NYPD was blindsided by the Mayor's announcement and was inadequately prepared to implement it[2], and that hospitals have limited capacity to deal with the influx of mental health detainees[3]. There are no current mechanisms for tracking the City employees' work under the Involuntary Removal Policy, no reference

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

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

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

to publicly reporting about the involuntary removals, and no mention of any oversight mechanism for the removals.

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

THE CITY MUST WHOLLY TRANSFORM ITS RESPONSE TO MENTAL HEALTH CRISES BY ELIMINATING POLICE AND REPLACING THEM WITH A PEER-LED HEALTH RESPONSE

In lieu of the Mayor's wholly wrongheaded policy of stepping up police involvement in dealing with individuals experiencing mental health crises, the City must join other cities across the country – including Los Angeles, San Francisco, Albuquerque, Denver, New Haven and many more – to ***remove*** **police** entirely from the equation, and **ensure that *healthcare* workers respond to *healthcare* crises.**

The City must establish a system whereby individuals who experience a mental health crisis receive appropriate services which will de-escalate the crisis and ensure their wellbeing and the wellbeing of all other New Yorkers. Only those who are trained in de-escalation practices should respond to a mental health crisis, and the most appropriate individuals to receive such training are peers (those with lived mental health experience) and health care providers[4]. Police, who are trained to

[4] Martha Williams Deane, *et al.*, "Emerging Partnerships between Mental Health and Law Enforcement," Psychiatric Services (1999), http://ps.psychiatryonline.org/doi/abs/10.1176/ps.50.1.99?url_ver=Z39.88-

uphold law and order are not suited to deal with individuals experiencing mental health crises, and New York's history of its police killing 19 individuals who were experiencing crises in the last six years alone, is sad testament to that. Eliminating the police as mental health crisis responders has been shown to result in quicker recovery from crises, greater connections with long-term healthcare services and other community resources, and averting future crises[5].

The scores of people experiencing mental health crises who have died at the hands of the police over the years is a microcosm of the police brutality around the world. Disability is disproportionately prevalent in the Black community and other communities of color[6], and individuals who are shot and killed by the police when experiencing mental health crises are disproportionately Black and other people of color. Of the 19 individuals killed by police in the last six years, 16 – or greater than 80% -- were Black or other people of color. The City Council simply cannot stand by while the killings continue. Now is the time for major transformations. Now is the time to remove – and certainly not add pursuant to the Mayor's new policy -- the police as responders to mental health crises. Lives are literally at stake.

2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&#/doi/abs/10.1176/ps.50.1.99?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed.

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

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

Correct Crisis Intervention Today – NYC (CCIT-NYC), which has over 80 organizational members including NYLPI, has developed the needed antidote. Modeled on the CAHOOTS (Crisis Assistance Helping Out On The Streets) program in Oregon, which has successfully operated for over 30 years without *any* major injuries to respondents or responders – let alone deaths -- the CCIT-NYC proposal is positioned to make non-police responses available to those experiencing mental health crises in New York City. The proposal avoids the enormous pitfalls of the City's B-HEARD pilot, which it inaccurately refers to as a non-police model. Hallmarks of the CCIT-NYC proposal are:

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

The full text of the CCIT-NYC proposal can be found at http://www.ccitnyc.org/whowe-are/our-proposal/.

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

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

- An astronomical **84% of all calls** in B-HEARD precincts continue to be **directed to the NYPD**, even twelve months after its kick-off.
- Even when all kinks are ironed out, the City anticipates continuing to have a nearly-as-astronomical **50% of all calls directed to the NYPD**.
- Moreover, **all calls continue to go through 911,** which is under the NYPD's jurisdiction.
- The entire **program is run by the Fire Department and other City agencies**, with ***NO*** **role whatsoever for community organizations**. And there is not even any delineation of the lines of authority and communication among the various city agencies.
- **The crisis response teams are composed of emergency medical technicians (EMTs) who are City employees** (from the Fire Department) **who are deeply enmeshed in the current police-led response system**. Peers do not trust

these EMTs. The other team members are *licensed clinical* social workers. Requiring both the licensure and the clinical orientation is unnecessary and precludes a vast array of potential candidates who have excellent skills and a long history of working with people experiencing crises.

- B-HEARD has ***NO* requirement to hire peers.**
- **The training of the teams does *NOT* require a trauma-informed framework, need *NOT* be experiential, and need *NOT* use skilled instructors who are peers or even care providers.**
- The anticipated **response time for crisis calls could be as long as half an hour**, and when last reviewed averaged over **fifteen minutes**, which is not even remotely comparable to the City's response times for other emergencies of 8-11 minutes.
- **The pilot operates only sixteen hours a day.**
- **There are no outcome/effectiveness metrics.**
- **There is no oversight mechanism.**

A comparison of the CCIT-NYC proposal, which is based on the CAHOOTS model with a stellar track record, and the B-HEARD program, which is not aligned with any best practices, is illustrated in the following chart:

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

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

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

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

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

We have long been on record opposing mandatory outpatient and inpatient treatment -- as insufficiently safeguarding the rights of persons with mental health concerns and failing to offer appropriate healthcare.

Quite simply, there is no place for coercion. Forced "treatment" is not treatment at all, and it has long been rejected by health practitioners -- to say nothing of the disability community – in favor of numerous best practices strategies that offer assistance even to those who have previously resisted offers of care[7].

[7] *See, e.g.,* de Bruijjn-Wezeman, Reina "Ending Coercion in Mental Health: The Need for a Human Rights-Based Approach," Committee on Social Affairs, Health and Sustainable Development, Council of Europe, Parliamentary Assembly, Doc. 14895 (May 22, 2019), https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=27701&lang=en.

There are multiple less invasive models of care[8] that New York City must invest in to avoid the tragedy and enormous cost of forced treatment. At the heart of these models are trained peers, which makes the model ideally suited to implement effective harm reduction and de-escalation techniques, especially during crises.

We know how to help those with the most severe mental illness, but we fail to do so because the services are insufficient or are not held to the highest accountability. We face complete system failure, yet we have done little to correct the failure, and even point our fingers at those most affected by the system failure. We must stop the finger pointing and fix the system. We must invest in innovative, voluntary health programs. And we must invest in supportive housing and not cart people off to a psychiatric ward or to jail.

Any proposal to ease the ability to force people into in-patient or out-patient "treatment" must be seen in the context of whom we're entrusting to "remove" these individuals. As we now surely know all too well, the police, who are steeped in law and order, are not at all well-suited to deal with individuals with mental health concerns. The Mayor's policy includes an outsized role for the police, and the City Council must halt it immediately.

Forced "treatment" must also be seen in the context of the ensuing racial disparities. Of the 19 individuals killed at the hands of New York police, 16 were people of color. This systemic racism also underlies the disproportionate prevalence

[8] *See* the attached list of long-term, voluntary programs that have excellent track records.

of disability in the Black community and other communities of color[9]. Likewise, racism is at the heart of the similarly vast disparities of forced treatment, which will only worsen if the Mayor's push for greater enforcement of commitment laws – alongside the governor – is not halted by City Council. The racial disparities in the application of forced outpatient treatment (also known as Kendra's Law) are vast. In New York City, since 1999, 77% of Kendra's Law orders are implemented against Black and Brown individuals[10].

While there is extensive literature supporting voluntary treatment, there is no support for the success of forced outpatient treatment generally, or Kendra's Law in particular. The studies which suggest that Kendra's Law has resulted in improved

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

10 *See https://my.omh.ny.gov/analytics/saw.dll?Dashboard&PortalPath=%2Fshared%2FAOT%2F_portal%2FAOT%20Assisted%20Outpatient%20Treatment%20Reports&Page=Characteristics%20-%20Demographic%20Characteristic&Action=Navigate&col1=%22AOT%20Characteristic%22.%22Characteristic%22&valsql1=%22SELECT%20%5C%22AOT%20Characteristic%5C%22.%5C%22Characteristic%5C%22%20FROM%20%5C%22AOT%5C%22%20%20where%20%5C%22AOT%20Characteristic%5C%22.%5C%22Characteristic%5C%22%20%3D%20%27%40%7Bcharacteristic%7D%7BRace%2FEthnicity%7D%27%22&psa1=%22AOT%22&col2=%22AOT%20Characteristic%22.%22Characteristic%22&valsql2=%22SELECT%20%5C%22AOT%20Characteristic%5C%22.%5C%22Characteristic%5C%22%20FROM%20%5C%22AOT%5C%22%20%20where%20%5C%22AOT%20Characteristic%5C%22.%5C%22Characteristic%5C%22%20%3D%20%27%40%7Bcharacteristic%7D%7BRace%2FEthnicity%7D%27%22&psa2=%22AOT%22&col3=%22AOT%20Characteristic%22.%22Region%22&val3=%22New%20York%20City%22&psa3=%22AOT%22&col4=%22AOT%20Characteristic%20Age%22.%22Region%22&val4=%22New%20York%20City%22&psa4=%22AOT%22&var5=dashboard.variables%5B%27characteristic%27%5D&val5=%22Race%2FEthnicity%22&psa5=%22AOT%22&var6=dashboard.currentPage.variables%5B%27region%27%5D&cov6=%22AOT%20Characteristic%22.%22Region%22&val6=%22New%20York%20City%22&psa6=%22AOT%22&var7=dashboard.currentPage.variables%5B%27region_age%27%5D&cov7=%22AOT%20Characteristic%20Age%22.%22Region%22&val7=%22New%20York%20City%22&psa7=%22AOT%22.*

circumstances for those with mental disabilities, did not undertake the necessary comparison between voluntary and involuntary treatment, and forced outpatient treatment certainly has never been proven to be a violence prevention strategy[11].

CONCLUSION

NYLPI respectfully requests that the Council:

- Halt the Mayor's policy of forcibly removing individuals perceived to have a mental illness diagnosis and perceived to be "unable to care for their basic needs," but who do not present a danger to themselves or others.
- Enact into legislation and fund the CCIT-NYC proposal to create a non-police, peer-driven mental health crisis response.
- Ensure that New Yorkers have access to a wide range of non-hospital, community-based mental health services that promote recovery and wellness, as well as a full panoply of community services, including housing, employment, and education, by allocating funding for such programs.

Thank you for your consideration. I can be reached at (212) 244-4664, ext. 311 or RLowenkron@NYLPI.org, and I look forward to the opportunity to discuss how best to respond to the needs of individuals experiencing mental health crises in New York City.

[11] *See* https://www.hmpgloballearningnetwork.com/site/behavioral/article/aot-cost-effectiveness-study-stirs-national-debate.

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About New York Lawyers for the Public Interest

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

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

Community Voluntary Long-Term Innovations for At-Risk Individuals

Residential

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

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

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

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

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

Safe Haven: provides transitional housing for vulnerable street homeless individuals, primarily women. "low-threshold" resources: they have fewer requirements, making them attractive to those who are resistant to emergency shelter. Safe Havens offer intensive case management, along with mental health and substance abuse assistance, with the ultimate goal of moving each client into permanent housing. https://breakingground.org/our-housing/midwood.

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

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

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

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

Non-residential

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

Intensive and Sustained Engagement Team (INSET): a model of integrated peer and professional services provides rapid, intensive, flexible and sustained interventions to help individuals who have experienced frequent periods of acute states of distress, frequent emergency room visits, hospitalizations and criminal justice involvement and for whom prior programs of care and support have been ineffective. MHA has found that participants, previously labeled "non-adherent," "resistant to treatment" or "in need of a higher level of care" and "mandated services," become voluntarily engaged and motivated to work toward

recovery once offered peer connection, hope and opportunities to collaborate, share in decisions and exercise more control over their lives and their services and supports. their treatment plans. Engaged 80% of people either AOT eligible or AOT involved. https://www.mhawestchester.org/our-services/treatment-support.

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

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

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

PROJECT GUARDIANSHIP
Changing the way we care for people.

Testimony for the NYC Council Committee on Fire and Emergency Management (Jointly with the Committee on Mental Health, Disabilities and Addiction, the Committee on Hospitals, and the Committee on Public Safety)

At the Oversight Hearing on Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan

Joann Ariola, Chair
Members: Carmen De La Rosa, Kevin C. Riley, Oswald Feliz, James F. Gennaro, Lynn Schulman, Robert F. Holden, Kalman Yeger, and David Carr

February 6, 2023

Submitted by Kimberly George, President and CEO, Project Guardianship

Thank you to the various Committees here for allowing me the opportunity to provide testimony today. My name is Kimberly George, and I am the President and CEO of Project Guardianship.

Project Guardianship is a recent spinoff of the Vera Institute of Justice and an independent non-profit organization providing comprehensive, court appointed guardianship services to hundreds of limited capacity New Yorkers citywide. We serve clients regardless of their ability to pay and provide services for some of the most compelling and complex cases in the city. Our clients include older New Yorkers living with serious mental illness, disability, dementia, substance misuse disorders, Traumatic Brain Injury, and other conditions that negatively impact their ability to make decisions. We also share research and recommendations for building a better guardianship system and advocate for a more equitable service response for people in need of surrogate decision-making supports or protective arrangements.

As you all know, in November 2022, Mayor Adams announced that first responders would be directed to remove and hospitalize people who appeared too mentally ill to care for themselves, regardless of whether those individuals consented to medical treatment. In doing so, the mayor indicated a need for additional resources for hospitals to accommodate the anticipated increase in psychiatric patients throughout the city. This increase will certainly have a ripple effect on a variety of related human services providers, including guardians.

This is because, according to data collected by the NYS Office of Court Administration, hospitals account for 25% of guardianship petitions brought in New York State. This occurs largely in cases where a patient cannot consent to services, a patient is unable to navigate Medicaid enrollment to cover their medical bills, and/or the hospital cannot arrange for a safe discharge. In most cases, the patients lack familial and other supports. According to a recent report by the American Bar Association, mental illness is the reason for guardianship appointments in approximately 20% of cases nationwide.

PROJECT GUARDIANSHIP
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Considering this data and our own experience serving as a legal guardian over the past 18 years, we know that an increase in hospitalizations will lead to an increase in guardianship petitions and appointments, and that – just like our hospitals – guardianship providers will also need more resources to meet that imminent need. Further, as more and more private attorneys are stepping away from guardianship practice due in part to the intense and time-consuming nature of the work alongside strict limitations on legal fees, judges are increasingly reliant on nonprofit providers to deliver these vital services. Nonprofits' interdisciplinary team-based models of employing case managers, finance associates, and attorneys offer guardianship clients the individualized, wrap-around support that solo private practitioners cannot.

Today, Project Guardianship serves as legal guardian for nearly 200 New York City residents. Not only are most of them very poor, but over half of our clients (54%) have diagnosed mental health disorders, such as schizophrenia, bipolar disorder, or post-traumatic stress disorder. As a mission-driven organization whose bottom line is the health, safety, and dignity of our clients, it is critical that our client-to-case manager ratio remain manageable so that the quality of our services – which often revolve around care coordination and keeping New Yorkers in their homes with Medicaid coverage and medical and mental health treatment – remains high.

We stand ready to respond to the imminent uptick in guardianship petitions and appointments due to Mayor Adams' directive, but we will need additional funding to meet the needs of these clients adequately and in the most person-centered way possible. We have and will continue to fill the gaps in our social safety net and will persist in connecting our clients to the housing, health and mental health care, legal and immigration services, and public benefits they need and deserve to gain stability and reduce their involvement with first responders and the hospital system. With additional support from the Council, we can offer our model of interdisciplinary services for more New York City residents who will undoubtedly enter guardianship arrangements as this directive is executed.

We hope to work with you as we strive to serve our fellow New Yorkers who may be impacted by this new directive.

Thank you for your time and consideration.

Please contact Kimberly George at kgeorge@nycourts.gov with any questions or requests for additional information.

Testimony before the New York City Council
Committee on Public Safety

Jointly with the Committee on Mental Health, Disabilities and Addiction, the Committee on Fire and Emergency Management and the Committee on Hospitals

February 6, 2023

Carli Wargo, LCSW, CASAC
Director of Harm Reduction Services
Director of Support and Connection Center

Project Renewal
www.projectrenewal.org

My name is Carli Wargo, I am Director of Harm Reduction and Director of the Support and Connection Center at Project Renewal, a New York City homeless services nonprofit agency. We thank Chair Hanks, Chair Lee, Chair Ariola, Chair Narcisse, and the City Council for this opportunity to testify.

For 55 years, Project Renewal has provided shelter, housing, health care, and employment services to New Yorkers experiencing homelessness. We especially focus on those affected by mental illness, substance use, and criminal justice involvement. We are grateful to the entire City Council for your support of our programs.

Amid conversations around how to connect the hardest-to-reach New Yorkers with mental health care, we wanted to highlight a program that is working: Project Renewal's Support and Connection Center, which opened permanently in late 2020.

In partnership with the NYC Department of Health and Mental Hygiene, the Center provides stabilization and treatment services for adults experiencing mental health and/or substance use crises. It's the first program of its kind in the city.

The Center's clients – whom we call "guests" – are referred by the NYPD as an alternative to arrest, summons, or the emergency room. We also get referrals from the Mayor's Subway Safety Task Force, the B-HEARD program, and co-response teams.

We now serve up to 18 guests at a time, for stays of up to five days. Guests have access to an interdisciplinary team of peer counselors and providers, including a psychiatrist and occupational therapist, in addition to meals, showers, and laundry. Our engagement is peer-led, and guests choose the services they receive, which is critical to building trust.

The program is an on-ramp to services for guests who are often disconnected and traumatized. For example, we recently engaged with a 64-year-old woman who had been sleeping on the subway and experienced years of homelessness. She met with our social workers and a psychiatrist, completed wellness plans with peers, and we secured a placement for her in an assisted living facility.

Critically, the Center fills a gap in the city's ecosystem of services for people experiencing homelessness, and acute mental health and substance use crises. We catch people who would otherwise fall through the cracks, provide them a safe space to access the services they need, and then connect them to longer term support.

We have now served over 650 New Yorkers at the Center. Upon completion of their stay, 54% of Center guests have chosen to stay engaged with our after-care services, which include connections to community services, long-term treatment, and housing. The after-care services allow us to continue to build engagement and trust, and ultimately support guests in remaining connected to the services they need.

Expanding the Support and Connection Center model could make a big difference in the lives of the hardest-to-reach New Yorkers. We are grateful to the New York City Council and the NYC Department of Health and Mental Hygiene for their support of Project Renewal's Support and Connection Center – and all of our services.

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VNS Health testimony to the New York City Council Committee on Mental Health, Disabilities, and Addictions, jointly with the Committee on Hospitals, the Committee on Fire and Emergency Management, and the Committee on Public Safety

Oversight: Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan

Monday, February 6, 2023

Good afternoon, Chairs Lee, Narcisse, Ariola, Hanks, and committee members of the City Council. My name is Jessica Fear, and I am the Senior Vice President of Behavioral Health at VNS Health (formerly Visiting Nurse Service of New York). I appreciate the opportunity to testify today.

Background

For almost 130 years, VNS Health has been meeting the healthcare needs of New York City residents in their homes and communities. As the largest home-and community-based healthcare organization in New York, VNS Health touches the lives of more than 43,000 people each day through a wide range of services, including skilled nursing and home care, hospice, long-term care, and behavioral health care.

With critical support from the New York City Department of Health and Mental Hygiene (NYC DOHMH), the NYC Council, and the New York State Office of Mental Health (NYS OMH), VNS Health provides home and community-based behavioral health treatment and case management services to vulnerable adults, children, and adolescents in every borough. We employ over 475 clinical staff, including licensed Behavioral Health Professionals, Psychiatrists, Psychiatric Nurse Practitioners, Care Managers, Outreach Workers, and Peers. In 2022, we provided care to over 20,000 NYC residents. An overview of our programs that are listed in the Appendix; they include Mobile Crisis Teams (MCTs), Assertive Community Treatment (ACT), Intensive Mobile Treatment (IMT), Home-Based Crisis Intervention (HBCI), and first responder mental health first aid training.

New York City's Mental Health Crisis

We applaud the City Council, the Adams Administration, and the Hochul Administration for shining the spotlight on the mental health crisis, and for providing the collaboration and resources necessary to address it. I serve on DOHMH Commissioner Ashwin Vasan's Stakeholder Committee to support people with Serious Mental Illness (SMI), and am committed to supporting the Commissioner's plan to improve access to care, prevent unnecessary suffering, and improve the quality of life for people with SMI.

So many of us are struggling to cope with what is happening around us – COVID, the fracturing of families and institutions, implicit and overt racism, violence, economic dislocation, our changing climate, and more. The individuals and families we serve are no different from you and me, except they exhibit a higher incidence of trauma, anxiety, and depression, and often need assistance accessing benefits and necessities such as housing, food, and medication.

Our mental health crisis took root well before COVID. Tragic incidents like New Yorkers being pushed onto subway tracks are indicators of a broader system failure. We all know that the "upstream" investments are critical to mitigate the "downstream" effects on individuals and our city. Systemic underinvestment in the institutions that keep people from falling through the cracks – behavioral health treatment capacity, family and youth support programs, and community-based programs for seniors and marginalized populations – has increased the number of vulnerable individuals suffering as a result.

Recommendations for Improved Mental Health Services

I cannot stress enough how imperative it is for community-based mental health programs to be sufficiently funded to prevent unnecessary hospitalizations and provide more cost-effective and stable patient care. VNS Health prides itself on meeting patients in their homes and communities to assess and treat them, helping to reduce the number of individuals with untreated SMI, including those who are currently unhoused or living outside the shelter system. Partnering with law enforcement is an important part of the process, but the *appropriate* deployment of law enforcement, and the proper training of first responders, is essential to de-escalation and avoiding hospitalizations that do not need to occur. Ensuring individuals can remain in their community whenever appropriate will preserve psychiatric bed capacity for those who need it most and reduce the burden on the overtaxed hospital system.

Below are our recommendations for enhancements to the system that will support meaningful change for the people we serve.

Expand Mobile Crisis Team (MCT) capacity: MCTs deploy clinically trained professionals within a 2-hour timeframe to de-escalate, engage, conduct a face-to-face assessment of psychiatric risk and risk of harm, and connect individuals to the right level of care, at the right time. To that end, only 5% of our mobile crisis clients are transported to the emergency room, with 3% of adults and 1% of youth under 21 transported involuntarily. The remainder are maintained successfully in the community. Between 2018 and 2022, we have seen MCT referrals more than double for adult and child and family services. We recommend funding to expand MCT capacity, and specifically to increase the number of Children's MCTs (there is currently only one 1 per borough) to ensure that all MCTs have the resources they need to respond quickly to a crisis.

Support Home-Based Crisis Intervention (HBCI): Preventing a crisis from escalating is critical to reducing the frequency of involuntary hospitalizations. VNS Health's Home-Based Crisis Intervention (HBCI) teams provide short-term intensive in-home intervention to families in crisis due to the imminent risk of their child being admitted to an inpatient psychiatric unit. As a result of the pandemic and the escalated youth mental health crisis, this program has been over capacity since 2021. Additionally, program funding runs lower than salary and expenses by about 40%, leading to challenges with recruitment and retention of skilled staff. We strongly recommend investing in this valuable program by funding additional HBCI teams with enhanced budgets for improved salaries and increased capacity.

Crisis intervention and 9.58 training for non-behavioral health service providers: In recent months, VNS Health has experienced increasing situations where clients in crisis encounter non-behavioral health service providers, and the interaction escalates to an untenable scale before we can intervene. These

situations nearly always result in a poor outcome for the person experiencing the mental health crisis. All personnel in positions where they could encounter individuals experiencing a mental health crisis, including non-first responder personnel in the NYPD, MTA, DOE, and NYCHA, should receive behavioral health crisis intervention training. Further, NYPD, FDNY, and EMT first responders need to be properly trained in how to assist with transporting people to emergency departments when deemed necessary by the MCT.

Address the behavioral health workforce shortage: A shrinking, high-turnover workforce is having a direct impact on our ability to care for the increasing number of clients who need our services. While it may be challenging to match the private sector, NYC should at least fund contracts that achieve salary parity between contracted mental health workers and City-employed mental health workers. Additionally, NYC should fund student tuition assistance or loan forgiveness and other initiatives to encourage more people from diverse backgrounds to enter the field and help NYC build a more robust pipeline of mental health professionals that reflects the communities they serve (VNS Health has a loan forgiveness program, none of the costs of which are included in the public programs we operate).

Public safety for behavioral health field staff: We are getting more consistent reports from our field-based staff finding themselves in unsafe situations and we are fielding more frequent safety threats related to harassment, discrimination (particularly our Asian staff), assault, and property crimes. The threats do not come from our clients, but from the areas where we engage with them. We are providing – at our own cost – car service expenses and walking escorts to accompany our staff when necessary. Public safety has a direct impact on staff recruitment and retention and by extension, access to care in the community for the people who need it most.

Conclusion

Addressing New York's mental health crisis and ensuring the most appropriate care for people with SMI will not be easy, and it will not be quick. Approaching this crisis from a place of compassion is essential, as well as building trust to achieve our common goals.

VNS Health looks forward to continuing to work with the Council and Administration to address NYC's mental health crisis. If you wish to learn more about our programs, please do not hesitate to reach out to me at jessica.fear@vnshealth.org |(212) 609-1535 or Dan Lowenstein, Senior Vice President of Government Affairs at dan.lowenstein@vnshealth.org | (212) 609-1514.

Appendix: VNS Health's Behavioral Health Programs and Partnerships

- **Mobile Crisis Teams (MCT):** VNS Health operates children's and adult MCTs in the Bronx, Brooklyn, and Queens. We partner with the City via NYC Well to deploy clinically trained professionals within a 2-hour timeframe to de-escalate, engage and conduct a face-to-face assessment of psychiatric risk and risk of harm, and connect individuals to necessary services. This program serves as a safety net for individuals in immediate need due to a psychiatric crisis. Since the start of the Covid public health emergency, our MCTs have received nearly double the referrals as in prior years. All MCTs operating in NYC transitioned to a two-hour response time in January 2021. This rapid response model means fewer calls requiring 911 or emergency services response.

- **Assertive Community Treatment (ACT):** ACT provides multidisciplinary, flexible, 24/7 community-based treatment and support to people with SMI. ACT helps address every aspect of a person's life, whether it be medication, therapy, social support, employment, or housing. ACT is intended for those who have transferred out of an inpatient setting yet require a similar level of comprehensive care in the community for some period of time.

- **Intensive Mobile Treatment (IMT):** Intensive Mobile Treatment teams provide intensive and continuous support and treatment to individuals right in their communities, where and when they need it. IMT Clients have had recent and frequent contact with the mental health, criminal justice, and homeless services systems, recent behavior that is unsafe and escalating, and were poorly served by traditional treatment models in recent months or years. IMT teams include mental health, substance use, and peer specialists who provide support and treatment, including medication initiation and maintenance, and facilitate connections to housing and additional supportive services.

- **Home-Based Crisis Intervention (HBCI):** HBCI offers an alternative to out-of-home placement for youth experiencing psychiatric distress. It is designed to provide short-term intensive in-home intervention to families in crisis due to the imminent risk of their child being admitted to an inpatient psychiatric unit. HBCI successfully and safely maintains youth in the community where they can be stabilized and connected to ongoing outpatient care. This program has been over capacity throughout 2021 due to the ongoing impact on children and adolescents of the COVID public health emergency.

- **9.58 Regulations Training**: VNS Health is the largest non-governmental 9.58 training provider for NYC DOHMH. The training on the 9.58 regulations is provided to certain field-based mental health staff who may encounter someone in the community experiencing a mental health crisis. We appreciate the opportunity to assist the City in offering this training and hope to expand this service to ensure that our first responders are properly equipped when encountering individuals with SMI.

- **Geriatric Outreach Programs:** VNS Health operates geriatric outreach programs in the Bronx and Manhattan, including the City Council-supported Geriatric Mental Health Initiative in the Bronx. With the goal of helping older adults remain at home and out of institutional care, we provide connections to support services and/or treatment organizations to address depression and alcohol/substance use disorders.

- **VNS Health FRIENDS Program**: This program provides a complete continuum of care for at-risk and seriously emotionally disturbed children, adolescents, and their families in the Bronx. The program provides a supportive, collaborative, and flexible model of care tailored to meet individual and family needs. It is operated out of our Article 31 outpatient mental health clinic in the Mott Haven neighborhood of the South Bronx and combines rapid response times for critical crisis intervention with direct access to ongoing therapeutic services, including medication initiation and management.

TESTIMONY FOR A HEARING ON:

Oversight – Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan

PRESENTED BEFORE:

THE NEW YORK CITY COUNCIL COMMITTEE ON MENTAL HEALTH, DISABILITIES, AND ADDICTION
Hon. Linda Lee, Chair

THE NEW YORK CITY COUNCIL COMMITTEE ON HOSPITALS
Hon. Mercedes Narcisse, Chair

THE NEW YORK CITY COUNCIL COMMITTEE ON FIRE AND EMERGENCY MANAGEMENT
Hon. Joann Ariola, Chair

THE NEW YORK CITY COUNCIL COMMITTEE PUBLIC SAFETY
Hon. Kamillah Hanks, Chair

PRESENTED BY:

Craig Hughes, MA, M. Phil, LMSW
Social Worker – Bronx Office
MOBILIZATION FOR JUSTICE, INC.

February 6, 2023

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I. Introduction

Mobilization for Justice's mission is to achieve justice for all. Mobilization for Justice (MFJ) prioritizes the needs of people who are low-income, disenfranchised, or have disabilities as they struggle to overcome the effects of social injustice and systemic racism. We provide the highest-quality free, direct civil legal assistance, conduct community education, and build partnerships, engage in policy advocacy, and bring impact litigation.

MFJ works withs individuals with mental illness across all our projects, but most saliently in our Mental Health Law Project and Housing Project. Our Mental Health Law Project was in the vanguard in 1983 when it first established units dedicated to serving people with mental health disabilities, partnering with outpatient mental health providers throughout New York City and with psychiatric units to provide legal services in conjunction with mental health treatment. By working as a team with mental health treatment providers, MFJ and its partners are able to avoid a client's loss of income or housing that so often accompanies deterioration in mental health or hospitalization. Additionally, to further expand our impact, we provide training to social service workers on housing, government benefits, and other problems that their clients might be facing. MFJ believes that housing is a human right, and our Housing Project focuses its work to ensure that tenants can stay in their housing and in their communities. We work with many individuals who have been chronically homeless, live in supportive housing, and who teeter on the edge of eviction with nowhere else to go. Moreover, MFJ clients are almost all financially impoverished and largely Black or brown, which makes them more likely to be targeted by police and accused of violating "quality of life" laws.

We have very serious concerns about the Mayor's recently announced involuntary removal initiative. In sum, the Mayor is pursuing a "Broken Windows" policing strategy and using the stigma of mental illness to justify a particularly cruel aspect of his effort. It must be seen in the context of other mayoral initiatives focused on sweeping homelessness out of sight. Our recommendations center on moving away from the Broken Windows framework that focuses on the symptoms of complex problems and moving toward tangible reforms to the supportive housing systems many vulnerable New Yorkers rely on.

II. Homelessness and Relevant Housing Resources in New York City

According to the most recent publicly available data, there are an estimated 73,130 homeless individuals sleeping in beds across 5 of the 6 municipal shelter systems.[1] This number is from October and includes the five longest running municipal shelter systems but does not include data from the newest City shelter system, which is run by the Health and Hospitals Corporation (HHC) and provides emergency shelter for at least 5,000 migrants in so-called Humanitarian

[1] This data is tallied from the October 2022 "Temporary Housing Report" issued pursuant to Local Law 37 of 2011. Although the City is obligated to publish the data monthly, the trend has been to delay its publication by months at a time. The Local Law 37 report provides data on individuals staying in the DHS, HRA-HASA, HRA-DV, DYCD and HPD shelter systems. The City began to open Humanitarian Emergency Response and Relief Centers (HERRCs) in fall of 2022. Legislators and advocates have argued that the HERRCs are a shadow shelter system for migrants that are a way for the City to skirt its right-to-shelter obligations.

Emergency Response and Relief Centers.[2] According to the most recent published point-in-time estimate of people living on the street, there are at least 3,455 individuals without any kind of shelter across the five boroughs, although the number is likely much larger.[3] In sum, there are at least 81,500 people in a shelter bed or on the street in New York City right now.

The decision to go into shelter is not an easy one for those we work with at MFJ. It typically comes after all alternative resources are exhausted and all alternative options ruled out. The main concerns voiced by those entering and living in shelters – and by those who sleep in public spaces instead of entering shelter – are the prevalence of safety issues. These safety concerns are often based on first-hand experience and include fears of assault, harassment, and theft. Restrictive curfews and exit/enter rules, which are unnecessary and paternalistic, also prevent people from accepting shelter.

The main cause of the homelessness in New York City, across the board, comes down to people being unable to afford available housing in a gentrified housing market and various forms of discrimination that many individuals face when trying to access housing with low incomes. Immediate drivers into shelter that appear not to boil down to economics, for example domestic violence, intersect with average rents that are far above what most people can afford, such that leaving shelter has become exceptionally difficult. Last year median rent for an apartment in Manhattan hit $4,000 per month, an historic peak.[4] According to recently released data from the Mayor's Office, just under sixty-seven percent of families with children in DHS shelters received public assistance, meaning their incomes were far too low to be able to afford a fraction of average city rents.[5]

According to data released by the state Office of Temporary and Disability Assistance (OTDA), there were 438,906 individuals receiving cash assistance in New York City as of December 2022.[6] Extremely low cash assistance benefits have been a major barrier to access or keep housing for poor families for many decades. Income limits are sharp, and families are quickly pushed off welfare rolls when they have another source of income. For a family of 4 with children receiving cash assistance in New York City, the maximum monthly benefit is just $951.70, which includes a maximum shelter allowance of $450 per month that the Human Resources Administration (HRA) pays to a given landlord.

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[2] Although City officials have scoffed at the idea that the HHC is running a shadow shelter system, City Council members, including CM's Hanif and Ayala, respectively, have rightfully raised this concern. See, for example, https://twitter.com/CMShahanaHanif/status/1604892689446670338. The 5,000 figure is from the testimony of Ted Long, Senior Vice President at HHC, to the Council's Committee on the Whole, December, 19, 2022.

[3] HUD's subpopulation dashboard for 2022 was only released recently and the data is from January 2022. The underlying methodology of the point-in-time survey (in New York City known as DHS's HOPE effort) has been widely criticized for producing a systematic undercount. See, for example: Chau Lam, "What you need to know about NYC's upcoming street homeless count," *Gothamist,* January 11, 2023. https://gothamist.com/news/what-you-need-to-know-about-nycs-upcoming-street-homeless-count.

[4] Deanna Garcia, "Manhattan median rent hits $4,000 for the first time, Douglas Elliman reports." *NY1.com,* June 9, 2022: https://www.ny1.com/nyc/all-boroughs/news/2022/06/09/manhattan-median-rent-hits--4-000-for-the-first-time--douglas-elliman-reports.

[5] Preliminary Mayor's Management Report – Department of Homeless Services, January 2023: https://www.nyc.gov/assets/operations/downloads/pdf/pmmr2023/dhs.pdf.

[6] OTDA's Caseload Statistics report for December 2022, p. 11: https://otda.ny.gov/resources/caseload/2022/2022-12-stats.pdf.

These numbers do not include individuals who receive Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) in New York City. SSI and SSDI are federal programs that provide marginal incomes for individuals with long-term disabilities that make it impossible to engage substantial and gainful employment. In December 2022, there were 363,929 SSI recipients in New York City.[7] For 2023, the maximum SSI cash benefit for an individual each month is just $914 each month.[8] For severely disabled individuals, HRA runs its WeCARE program that provides an exemption from welfare-to-work programs while someone is applying for SSI, after they have completed onerous eligibility assessments.[9]

Many poor individuals in New York City are able to access one or another rental subsidy in New York City to help manage the mismatch between income and rents.[10] For those with serious and persistent mental illness, shelter providers, outreach providers, and City officials generally argue that supportive housing is the best resource available. Supportive housing units typically include in-place subsidies (whether through federal Section 8 resources or local or other supports) that allow an individual's rental payment to max out at 30% of their income. Supportive housing, generally speaking, includes access to a room or a whole apartment that is adjoined by case management and other assistance. As we discuss below, New York City's supportive housing systems are plagued with underacknowledged problems. Nonetheless, this is the main resource that many unsheltered individuals and people with severe mental illness are steered to and access to exit homelessness, and for many people it has been lifesaving. While some individuals on the street or who have known severe mental illness are sometimes able to access other subsidies, such as CityFHEPS, they, like many others, face pervasive discrimination against voucher holders by brokers and landlords.

III. Supportive Housing

According to the most recent public data, there are 35,270 supportive housing beds in New York City.[11] Supportive housing in New York City, while generally seen as the panacea for people who are chronically homeless who suffer from serious mental illness, very often fails those it is marketed as helping. Accessing supportive housing is a highly bureaucratic and discretionary process, and as of late last year nearly 2,600 supportive housing units were vacant across the five boroughs.[12] While supportive housing has been key to helping thousands of people to exit homelessness, and is an important piece of the puzzle for ending homelessness, its development

[7] OTDA Temporary and Disability Assistance Statistics report for December 2022, p. 20: https://otda.ny.gov/resources/caseload/2022/2022-12-stats.pdf.
[8] SSI Federal Payment Amounts for 2023: https://www.ssa.gov/oact/cola/SSI.html.
[9] See MFJ's "How do I keep from losing my public assistance benefits because of work assignment sanctions?" https://mobilizationforjustice.org/wp-content/uploads/How-Do-I-Keep-from-Losing-My-Public-Assistance-2016.pdf.
[10] Access to rental subsidies varies by shelter system. For example, young adults in DYCD shelters don't generally have access to the CityFHEPS subsidy, and neither do individuals in HPD shelters. Individuals and families in HERRCs have no access to any rental subsidy to help them exit shelter.
[11] Data from the 2022 HUD Housing Inventory Count, which is as of January 2022: https://files.hudexchange.info/reports/published/CoC_HIC_CoC_NY-600-2022_NY_2022.pdf.
[12] Andy Newman, "Nearly 2,600 Apartments for Mentally Ill and Homeless People Sit Vacant," *New York Times* November 4, 2022: http://www.nytimes.com/2022/11/04/nyregion/nearly-2600-apartments-for-mentally-ill-and-homeless-people-sit-vacant.html.

in New York City has not lived up to its promise, and increasingly the supportive housing has industry moved away from the low-barrier principles that should be guiding it.

In 2021, as a result of organizing by supportive housing applicants and tenants, the New York City Council passed Intro-147/2018, which became Local Law 3 of 2022.[13] The law mandated an annual report, to be produced by the Department of Social Services (DSS), that provides data on the supportive housing application and placement process.

The Local Law 3 report showed what advocates and applicants had been saying for years – providers are granted the latitude to deny someone housing for virtually any reason they want, which sometimes includes violations of disability and other rights.[14] Often, in fact, providers state that someone's lack of "insight" is the reason they cannot be approved for placement into an apartment.

According to the same report, individuals whose application was completed while they were living on the street were only able to access a supportive housing apartment 16 times in FY22.[15] Hyper-subjective "cherry-picking" or "creaming" of applicants – which often amount to discrimination by disability – have pervaded the supportive housing systems in New York City for decades.[16] Yet, more than a year into the Adams administration, there have been no policy changes by City officials to reign in "creaming" or discriminatory behavior by providers, so it continues unabated. As discussed below, this directly relates to the Mayor's involuntary removal policy: the individual's targeted by the Mayor's mental health initiative are, in fact, least likely to get access into a supportive housing bed.

Those fortunate enough to finally get access to a supportive housing bed often find that providers actually offer little tangible support, are quick to blame tenants for terrible conditions, and that individuals are often placed into dilapidated and disinvested "scatter site" units run by notoriously bad landlords.[17] Moreover, many tenants often find themselves being brought to Housing Court for issues like non-pay or holdovers based on allegations that are untrue or occur because of the lack of support they've been given by a provider. Housing Court is often weaponized by supportive housing providers to get tenants to behave in ways they want or to get rid of tenants that providers find "difficult."

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[13] Department of Social Services report pursuant to Local Law 3 of 2022: https://www1.nyc.gov/assets/hra/downloads/pdf/news/HRA-Local-Law-3-CFY2022-08302022.pdf.

[14] David Brand, "NYC Council Considers Bill to Probe Why Homeless Are Denied Supportive Housing," *City Limits,* November 29, 2021: https://citylimits.org/2021/11/29/nyc-council-considers-bill-to-probe-why-homeless-are-denied-supportive-housing/.

[15] Department of Social Services report pursuant to Local Law 3 of 2022, p.53.

[16] Josh Leopold, *Innovations in NYC Health & Human Services Policy: Street homelessness and Supportive Housing*. Urban Institute, February 2014: https://www1.nyc.gov/assets/opportunity/pdf/policybriefs/street-homelessness-and-supportive-housing.pdf.

[17] David Brand, "'It's Like a Slum': Supportive Housing Tenants Cope with Violation-Filled Homes. Provider Blames Underfunding," *City Limits*, July 13, 2022: https://citylimits.org/2022/07/13/its-like-a-slum-supportive-housing-tenants-cope-with-violation-filled-homes-provider-blames-underfunding/.

An alternative approach to supportive housing, distinct from what is typically found in New York City, is the Housing First model, which was piloted in New York City in the 1990s.[18] Housing First is an approach to housing individuals with substance use struggles and serious mental illness, where placement into an apartment is seen itself as a key step toward helping them stabilize or recover. Services are offered voluntarily and at the individual's pace. The model respects an individual's decisions and their self-determination.[19] In contrast, the supportive housing systems in New York City are administered and operated in ways that deviate significantly from this evidence-based model, and providers often deny housing to those whose symptoms of serious mental illness, or whose histories, are of concern to them.

In sum, while supportive housing has been portrayed as the panacea to house unsheltered individuals and those with serious and persistent mental illness, the reality in New York is a much more complicated picture. Applicants for supportive housing find themselves navigating a bureaucratic maze, where they are coerced to disclose their most sensitive parts of their lives to strangers who gatekeep access to supportive housing units, and can decide, for virtually any reason they want, to deny the applicant housing. Tenants in supportive housing face defensive and sometimes harassing providers who weaponize the legal system against them while often failing to provide the services that may help someone stay housed. Neither City or State government track evictions from supportive housing, so it is unknown how many people find themselves going from supportive housing back to the streets or shelters.

IV. The Mayor's Involuntary Removal Plan

The Mayor's plan was an announcement of formal agreement with interpretive guidance by the state Office of Mental Health (OMH) issued in February of 2022. The OMH interpretive guidance supported police and clinicians in involuntarily removing individuals with a "suspected" mental illness, even if the individual did not appear "imminently dangerous."[20]

The plan announced by Mayor Adams is composed first and foremost of a directive, issued on November 28, that "clarifies" the municipal reading of forced removals under State regulations 9.58 and 9.41. Per the directive, involuntary removals will be permitted without the risk of imminent harm to self or others, "If the circumstances support an objectively reasonable basis to conclude that the person appears to have a mental illness and cannot support their basic human needs to an extent that causes them harm…"[21] In other words, someone's financial poverty will support the forced removal of individuals who may be unsightly to some observers, and individualized assessments about the "appearance" of someone's mental illness will allow their involuntary removal.

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[18] The National Alliance to End Homelessness has published a succinct and helpful factsheet on Housing First, available at: https://endhomelessness.org/resource/housing-first/

[19] See D. Padgett et al. 2015. *Housing First: Ending Homelessness, Transforming Systems, and Changing Lives.* New York: Oxford.

[20] NYS Office of Mental Health Memorandum, "Interpretative Guidance for the Involuntary and Custodial Transportation of Individuals for Emergency Assessments and for Emergency and Involuntary Inpatient Psychiatric Admissions," February 18, 2022, https://omh.ny.gov/omhweb/guidance/interpretative-guidance-involuntary-emergency-admissions.pdf

[21] City of New York, "Mental Health Involuntary Removals," available at: Mental-Health-Involuntary-Removals.pdf (nyc.gov). The plan was announced on November 29, 2022.

Following the November announcement, on December 6, 2022, the NYPD issued a FINEST memo, to all commands, about involuntary removals under Mental Health Law Section 9.41. The memo explained,

> Officers should continue to remove a person for evaluation when that person appears mentally ill and the person's actions present a threat of serious harm to themselves or others. But officers should also be aware that removal is also appropriate when a person appears to be mentally ill and incapable of meeting basic human needs and such neglect is likely to result in serious harm to that person.[22]

The Mayor's announcement in November came nearly a year into efforts by his administration to remove homeless people from subways and sidewalks across the City, relying on outreach workers, Sanitation trucks, and an "omnipresence" of police.[23] As we discuss below, while the November announcement used the language of mental illness, it functions as just another step in the Mayor's efforts to use force to get homeless people out of sight, directly in line with his administration's commitment to the bankrupt and racist theory of Broken Windows policing.

A timeline of the initiatives that preceded the November announcement will help to contextualize it.

Timeline of Announcements and Initiatives

January 6, 2022	Announcement of deployment of an "omnipresence" of police in subway system
January 24, 2022	Blueprint to End Gun Violence section homelessness
February 18, 2022	Subway Safety Plan
March 25, 2022	Aboveground Encampments Initiative
November 29, 2022	Announcement of Involuntary Removal Plan

On January 24, 2022, the Mayor announced his administration's Blueprint to End Gun Violence, which included an early rendition of what would later appear in the Mayor's involuntary removal plan. The Blueprint explained,

> In the immediate future, we will revisit existing law so that if someone who can't take care of themselves refuses treatment, they can be hospitalized if that is what a doctor and judge recommend, and that we are using that in the most targeted way possible, especially for people with a documented history of violence.[24]

However, Mayor Adams's first major intervention into public homelessness came just days after the announcement of the Blueprint to End Gun Violence, with the announcement of

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[22] NYPD FINEST Message, to all commands, re: INVOLUNTARY REMOVALS UNDER MENTAL HEALTH LAW SECTION 9.41, dated December 6, 2022.

[23] Marcia Kramer, "Mayor Eric Adams Unveils 'Omnipresence' Police Plan To Get Homeless Off The Subways," *CBS2*, January 6, 2022: https://www.cbsnews.com/newyork/news/nypd-omnipresence-plan-homeless-nyc-subways-kathy-hochul-keechant-sewell/.

[24] City of New York, "The Blueprint to End Gun Violence," p. 8: https://www1.nyc.gov/assets/home/downloads/pdf/press-releases/2022/the-blueprint-to-end-gun-violence.pdf.

the Subway Safety Plan (SSP).[25] The SSP discussed homelessness in the MTA system through the lens of Broken Windows and quality-of-life policing, such as an "increased NYPD presence" and "rules of conduct enforcement." We discuss this more below.

The SSP includes mental health professionals like "Neighborhood Response Units" run by the Department of Health and Mental Hygiene (DOHMH), but at the core of the effort are police officers. Officers are to enforce no-sleeping ordinances on public trains, and the plan includes a continuation of the "End of Line" initiative began under Mayor de Blasio, which forces homeless people off trains at select endpoint stations.[26]

Notably, as part of the SSP, Mayor Adams did announce significant investments in new "safe haven" beds, which have less onerous rules and are often experienced as more private and safer than traditional congregate shelters. While it is accurate that there is a desperate need for additional safe haven and stabilization bed capacity, it was regrettable that the Mayor tied these investments to a plan that simultaneously aimed to police homelessness out of sight. Recent data has shown that the vast majority of people removed from the subways are simply disappearing after removal, and most who are showing up at shelters are being sent to traditional congregate sites.[27] Additionally, after the announcement, it became known that many of the new safe haven beds are in congregate arrangements, which many people on the street reject – often based on past negative experiences.

Soon after the announcement of the SSP, in March, Mayor Adams announced another initiative targeting public homelessness. This was the aboveground encampments initiative.[28] Under this initiative, the City redoubled its efforts to clear homeless encampments, building on sweep efforts that had vastly accelerated under the preceding administration.[29] The Adams administration quickly moved to place the NYPD into the position of coordinating and having the final say in cross-agency encampment sweeps, and made the chain of command official in an August 2022 policy issued by the Department of Homeless Services.[30] In November, it was

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[25] "Mayor Adams Releases Subway Safety Plan, Says Safe Subway is Prerequisite for New York City's Recovery," February 18, 2022: https://www.nyc.gov/office-of-the-mayor/news/087-22/mayor-adams-releases-subway-safety-plan-says-safe-subway-prerequisite-new-york-city-s#/0.

[26] David Brand, "City's Homeless Services Head Hails Moves Out of Subway, But Won't Say How Many Stay in Shelter," *City Limits*, May 3, 2022: https://citylimits.org/2022/05/23/citys-homeless-services-head-hails-moves-out-of-subway-but-wont-say-how-many-stay-in-shelter/.

[27] David Brand, "Few Homeless New Yorkers Moving from Subways to Safe Havens, As Enforcement Continues," *City Limits*, Dec. 15, 2022: https://citylimits.org/2022/12/15/few-homeless-new-yorkers-moving-from-subways-to-safe-havens-as-enforcement-continues/.

[28] Andy Newman, Katie Glueck and Dana Rubinstein, "Adams Says Encampments of Homeless People Will Be Cleared," *New York Times*, March 25, 2022: https://www.nytimes.com/2022/03/25/nyregion/eric-adams-homeless-encampments.html.

[29] Nicholas Williams et al, "Critics say Mayor Adams didn't learn lesson from 9,000 homeless encampments torn down by de Blasio," *NY Daily News*, March 31, 2022: https://www.nydailynews.com/new-york/ny-homeless-encampment-crackdown-de-blasio-adams-20220331-7c7eu5uusvganjt6bq6ppoylby-story.html.

[30] David Brand, "The NYPD Now Decides What Homeless Encampments Get Swept," *City Limits*, September 21, 2022: https://citylimits.org/2022/09/21/the-nypd-now-decides-what-homeless-encampments-get-swept/.

reported that just 5% of the thousands of people targeted for sweeps actually entered a City shelter.[31]

Since the SSP and aboveground encampment initiative were announced in 2022, people who bed down in public places have faced thousands of forced displacements. Last month, the NYPD took things a step further, with officers being directed to issue tickets for misdemeanor offenses of having unattended property or erecting "structures."[32] Since the individuals on the receiving end of these directives are typically extremely poor, paying fines will be exceptionally difficult and often impossible, which will lead to warrants and, eventually, incarceration.

Finally, it is important to note that the Mayor's plan does not include anything about improving the supportive housing system. In fact, in comments in recent months, he has all but rejected a 'Housing First' approach.[33] Rather than reforming the front door of the supportive housing systems to better serve those bedding down in public place, that Mayor's plan leans heavily on coercion and criminalization.

V. Broken Windows Redux

As a result of the work of organizers and social justice movements, the theory of Broken Windows policing has become a controversial topic in New York City.[34] As a result, Broken Windows tactics and policies are sometimes put forward without claiming them as such. The Mayor's homeless displacement and removal initiatives boil down to Broken Windows policing, relying on the language of "dignity" and "mental health" to justify strategies that have caused vast harm to poor and working-class Black and brown communities in New York City for decades.

The theory of Broken Windows is rooted in a 1982 article by George Kelling and James Q. Wilson published in the popular magazine *The Atlantic*.[35] The theory is focused on "the process whereby one broken window becomes many." Its authors explain,

> The unchecked panhandler is, in effect, the first broken window. Muggers and robbers, whether opportunistic or professional, believe they reduce their chances of being caught or even identified if they operate on streets where potential victims are already intimidated by prevailing conditions. If the neighborhood cannot keep a bothersome

[31] Chau Lam, "Mayor Adams' homeless encampment sweeps result in just 115 people entering NYC shelters," *Gothamist*, November 30, 2022: https://gothamist.com/news/mayor-adams-homeless-encampment-sweeps-result-in-just-115-people-entering-nyc-shelters.

[32] Craig McCarthy, Reuven Fenton and Kyle Schnitzer, "NYPD mulls new tactic to curb rampant homelessness," *New York Post*, January 18, 2023: https://nypost.com/2023/01/18/nypd-mulls-new-tactic-to-curb-rampant-nyc-homelessness/.

[33] David Brand, "NYC Pilots 'Housing First' Plan for Handful of Homeless Adults," *City Limits*, November 15, 2022: https://citylimits.org/2022/11/15/nyc-pilots-housing-first-plan-for-handful-of-homeless-adults/.

[34] See, for example, Jaime Dejesus, "End Broken Windows town hall held in Sunset," *Brooklyn Reporter*, July 15, 2017: https://brooklynreporter.com/2017/07/end-broken-windows-town-hall-held-sunset/.

[35] George L. Kelling and James Q. Wilson, "Broken Windows The police and neighborhood safety," *The Atlantic* March 1982: https://www.theatlantic.com/magazine/archive/1982/03/broken-windows/304465/

> panhandler from annoying passersby, the thief may reason, it is even less likely to call the police to identify a potential mugger or to interfere if the mugging actually takes place.

Broken Windows theory has guided policing since the Dinkins administration of the 1990s.[36] Racial justice activists have pointed out that implementation of the theory "has led to the criminalization of poverty and the over-policing of Black and Brown communities at disproportionate rates." In fact, as activists have stated, "the theory has never been proven to be effective at reducing crime."[37] A 2006 study evaluating the claims of Broken Windows theory, by scholars Bernard Harcourt and Jens Ludwig, concluded that "there appears to be no good evidence that broken windows policing reduces crime, nor evidence that changing the desired intermediate output of broken windows policing- disorder itself-is sufficient to affect changes in criminal behavior."[38] More recent studies, published in 2019, found that Broken Windows theory is an unsubstantiated proposition.[39]

Yet, even without supporting evidence, Mayor Adams and NYPD Commissioner Sewell have voice support for the baseless theory. Upon her appointment to Commissioner, Sewell told the *New York Post* that she believed in Broken Windows theory, stating: "I think you have to take a look at quality-of-life crimes because sometimes they lead to something else […] You have to make sure you're using the broken windows theory, the enforcement of those low-level crimes, in a way that's not discriminatory, in a way that addresses the problem and doesn't actually over police it in some respect."[40] In March of last year, Commissioner Sewell announced an initiative focused on "quality of life" issues.[41]

Mayor Adams has also long been vocal as a supporter of Broken Windows policing, though he has more recently sought to temper this support with statements like "we won't go back to abusive policing."[42] Writing in 2015, reflecting an experience from his past role as a police platoon commander, then-Borough President Adams recalled seeing an elderly woman holding a bible and singing hymns, in a municipal precinct holding cell, where she was detained for a warrant resulting from an unpaid traffic ticket. He explained,

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[36] On the history of the implementation of Broken Windows theory in New York City, see: Alex S. Vitale, *City of Disorder: How the Quality of Life Campaign Transformed New York Politics*. NYU Press, 2008.
[37] A useful resource for understanding what Broken Windows has meant in practice see NYCLU's "Museum of Broken Windows" project, https://www.museumofbrokenwindows.org/tour
[38] Bernard E. Harcourt & Jens Ludwig, "Broken Windows: New Evidence from New York City and a Five-City Social Experiment," 271 *University of Chicago Law Review* 316 (2006).
[39] Summaries of the research can be found at "Northeastern University researchers find little evidence for 'broken windows theory,' says neighborhood disorder doesn't cause crime," https://news.northeastern.edu/2019/05/15/northeastern-university-researchers-find-little-evidence-for-broken-windows-theory-say-neighborhood-disorder-doesnt-cause-crime/.
[40] Julia Marsh and Craig McCarthy, "Eric Adams picks Keechant Sewell as the first female police commissioner of the NYPD," *New York Post*, December 14, 2021: https://nypost.com/2021/12/14/keechant-sewell-named-nypds-first-female-police-commissioner/
[41] "NYPD Announces Citywide Crime and Quality-of-life Enforcement Initiative," March 23, 2022: https://www.nyc.gov/site/nypd/news/p00040/nypd-citywide-crime-quality-of-life-enforcement-initiative.
[42] Anna Lucente Sterling, "We won't go back to abusive policing': Adams defends new quality-of-life initiative," *NY1*, March 25, 2022*:* https://www.ny1.com/nyc/all-boroughs/news/2022/03/25/adams--quality-of-life-policing-does-not-equal--broken-windows--.

> Even after experiencing an encounter like this, I continue to be an ardent supporter of "broken windows" policing. After patrolling our streets for 22 years as an NYPD officer, witnessing the transformation of New York City from an incubator of crime to the safest big city in America, I know firsthand that we cannot tolerate quality-of-life disturbances.[43]

While Mayor Adams has avoided the term "broken windows" during his time in office, his policies reflect a straightforward commitment to Broken Windows, and his public comments often reflect the terminology underlying the Broken Windows theory. Between January and June of 2022 misdemeanor arrests increased by 25%, with people of color composing 90% of those placed in cuffs. Fare evasion arrests more than doubled between 2021 and 2022.[44] The Mayor often speaks of "disorder," recently commenting on *1010WINS* that flooding the subway with police last fall was about homelessness and the perception of disorder, stating "we were dealing with homelessness, the feeling of disorder. We knew we had to have a comprehensive approach and that's what we put in place in the second wave that was in October."[45] Targeted low-level crimes, which often amount to crimes of poverty, and relating homelessness to "disorder" are hallmarks of Broken Windows. There is nothing new about this in New York City.

Speaking to the press in late January, the Mayor directly linked the Subway Safety Plan to his newly announced involuntary removal initiative. He stated,

> But those customer satisfactory surveys are saying, "Hey, we like what we're seeing. We like how they did the Subway Safety Plan. We're moving in the right direction. We have to continue to do so." But what's really challenging is that when we see that homeless person and we know they can't take care of themselves, some of our laws are restricting us from doing the involuntary removal that's needed. Police officer can't do anything if the person is uncared, is on our subway system and is sitting on our subway system and we know that this person needs additional... We cannot have stronger laws to allow us to carry that action out. It's really handcuffing our police officers, is handcuffing our outreach workers that are really leading this challenge of making sure that we give people the care they deserve. Sid, I'm clear. It is inhumane to allow people to live on the streets, live in the subway system if they cannot take care of their basic needs and they're endangered to themselves. That's just inhumane and whoever want that status quo, I don't subscribe to.[46]

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[43] Eric Adams, "Locking up New York's Future," *New York Daily News*, April 30, 2015, p. 27. It is important to note that the gist of then-Borough President Adams' op-ed is that Broken Windows was correct, but he wrote in support of a Council bill to shift penalties for certain criminal offenses to civil offenses, with civil penalties. Under his administration, as mentioned above, the NYPD have moved to begin ticketing homeless individuals for misdemeanor crimes.

[44] Fola Akinnibi, "Arrests for Low-Level Crimes Climb Under NYC Mayor Eric Adams," *Bloomberg News*, August 30, 2022: https://www.bloomberg.com/news/articles/2022-08-30/nyc-s-rise-of-low-level-arrests-worry-critics-of-broken-windows-era.

[45] "Transcript: Mayor Eric Adams Calls in Live to 1010 WINS' "Morning Drive," January 27, 2023: https://www.nyc.gov/office-of-the-mayor/news/070-23/transcript-mayor-eric-adams-calls-live-1010-wins-morning-drive-.

[46] "Transcript: Mayor Eric Adams Calls in Live to WABC's "Sid & Friends in the Morning" Radio Show," Januarey 25, 2023: nyc.gov/office-of-the-mayor/news/062-23/transcript-mayor-eric-adams-calls-live-wabc-s-sid-friends-the-morning-radio-show.

VI. Broken Windows through the Language of Mental Health

In July of last year, Mayor Adams appointment Brian Stettin as the administration's Senior Advisor for Severe Mental Illness.[47] Mr. Stettin was already well known in the field of mental health policy. Mr. Stettin was an assistant attorney general in Eliot Spitzer's office when he was assigned the task of researching what would become Kendra's Law,[48] which, in 1999, established court-mandated treatment through the Assisted Outpatient Treatment (AOT) program in New York.

In 2013, Mr. Stettin published an op-ed in the *Daily News* where he argued many of the points Mayor Adams has put forward to justify his new involuntary removal policy. Specifically, Stettin argued a decade ago,

> A major failure of the state's mental health system — unrelated to Kendra's Law and unaddressed by last week's reforms…is its overly restrictive standard for hospital commitment. Because mental illness often prevents a person from recognizing his own need for treatment, the availability of involuntary hospitalization is critical.[49]

In 2021, Mr. Stettin wrote another op-ed for the *Daily News*, where he argued,

> The Adams administration should issue directives to police, all city personnel conducting field evaluations of individuals in crisis, and doctors in city-operated hospitals, that these standards should be reasonably interpreted to encompass as dangerous-to-self any individual whose untreated mental illness prevents them from meeting basic survival needs, i.e., proper food, clothing, shelter and medical care.[50]

At the time, Mr. Stettin was Policy Director of the Treatment Advocacy Center, an organization that pushes for mandated treatment policies nationwide, and was founded by controversial psychiatrist E. Fuller Torrey.[51] Torrey, as recently pointed out by the *New York Times*, built his career advocating for neurobiological interpretations of severe mental illness and the need for compulsive "treatment."[52] Mr. Stettin has publicly voiced the impact Dr. Fuller Torrey has had on his thinking. As explain in the aforementioned *New York Times* article,

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[47] "Mayor Adams Appoints Eva Wong as Director of Mayor's Office of Community Mental Health, Brian Stettin as Senior Advisor for Severe Mental Illness," July 11, 2022: https://www.nyc.gov/office-of-the-mayor/news/488-22/mayor-adams-appoints-eva-wong-director-mayor-s-office-community-mental-health-brian.

[48] Brian Stettin, "Personally Speaking: The Law is Personal," https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/4327-personally-speaking-the-law-is-personal-.

[49] Brian Stettin, "New York's True Mental Health Problem," *New York Daily News*, January 23, 2013:: https://www.nydailynews.com/opinion/n-y-s-true-mental-health-problem-article-1.1245186.

[50] Brian Stettin, "New York City needs a sanity check: Simon Martial, Michelle Go and all of us," January 23, 2021 https://www.nydailynews.com/opinion/ny-oped-kendras-law-20220123-tt2yjn3tibguhhwjxiezid25ly-story.html.

[51] "Our History," Treatment Advocacy Center, https://www.treatmentadvocacycenter.org/about-us/our-history

[52] Ellen Barry, "Behind New York City's Shift on Mental Health, a Solitary Quest," *New York Times*, December 11, 2022: https://www.nytimes.com/2022/12/11/health/fuller-torrey-psychosis-commitment.html.

> At the time, Mr. Stettin turned to Dr. Torrey's organization, the Treatment Advocacy Center, for guidance and became such a believer that after leaving state government, he spent more than a decade as the group's policy director. In an interview, Mr. Stettin described Dr. Torrey as "the single greatest influence on my thinking about the role of law and policy in ensuring the medical treatment of severe mental illness.[53]

On December 20, 2022, Mr. Stettin, the administration's Senior Advisor on Severe Mental Illness, co-authored an opinion piece in the *New York Daily News* that stated,

> In reality, the Adams plan consists of a few sensible measures narrowly focused on meeting the urgent needs of a small subset of the unsheltered whose mental illness places them in danger. Many suffer from anosognosia — a part of their brain disease that robs them of insight into their current grave condition. Often delusional, they resist voluntary treatment for diseases they don't know they have and their symptoms, left untreated, become ever more ruinous.[54]

As part of Mayor Adams efforts to use Kendra's Law in line with efforts to push people off of the streets, he and members of the administration have increasingly deployed arguments about what the Treatment Advocacy Center and others have called "anosognosia."

Anosognosia is a concept historically rooted in early twentieth century efforts in neurology to understand post-stroke behavior.[55] In recent decades certain researchers and policy analysts have sought to transform the neurological concept of "anosognosia" into a psychiatric concept of "insight,"[56] increasingly relying on brain scans to support controversial and paternalistic arguments that people with serious mental illness – particularly schizophrenia and bipolar disorder – must be mandated into treatment if they refuse voluntarily.[57] However, the fact is that there is no consensus in the field of psychiatry about either the root causes of serious mental illness or the psychiatric use of the concept of "anosognosia." Indeed, as psychiatrists associated with the University of California wrote in a 2018 article, "We caution against using this term to provide validity to arguments for coercion. It not only implies a type of brain dysfunction that

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[53] *Ibid.*

[54] Brian Stettin and Norm Ornstein, "The truth behind the Adams plan on serious mental illness," *New York Daily News*, December 20, 2022: https://www.nydailynews.com/opinion/ny-oped-serious-mental-illness-20221220-irouakmrvveqvcfig4v7tcmnxa-story.html.

[55] John Cutting, "Study of Anosognosia." 1978. *Journal of Neurology, Neurosurgery and Psychology,*. https://jnnp.bmj.com/content/jnnp/41/6/548.full.pdf.

[56] Sociologist Neil Gong traces this transformation in his 2017 article, "That proves you mad, because you know it not": impaired insight and the dilemma of governing psychiatric patients as legal subjects," *Theory and Society* 46, pp. 201-228.

[57] See, for example, DJ Jaffe, *Insane Consequences: How the Mental Health Industry Fails the Mentally Ill*. New York: Prometheus, pp. 72-73. On page 91, Jaffe states, "Assisted Outpatient Treatment (AOT) is a useful alternative to inpatient commitment, especially for those with anosognosia. State laws vary, but generally AOT allows judges, after full due process, to order untreated seriously mentally ill people who meet narrow and specific criteria to stay in, say, six months of mandated and monitored treatment while they continue living freely in the community." Jaffe had worked with the Treatment Advocacy Center and the forward to his book was written by Fuller Torrey.

has yet to be substantiated by the evidence but also implies that the presence of a brain difference is an adequate rationale for forced treatment."[58]

Even still, the Mayor has deployed this argument to support an extremely controversial public policy, and in in extremely broad ways. When he announced the involuntary removal initiative, on November 29 of last year, he was clear on the underlying philosophy:

> These New Yorkers and hundreds of others like them are in urgent need of treatment, yet often refuse it when offered. *The very nature of their illnesses keeps them from realizing they need intervention and support.* Without that intervention, they remain lost and isolated from society, tormented by delusions and disordered thinking. They cycle in and out of hospitals and jails" (emphasis ours).[59]

This incredibly overbroad statement that "the very nature of their illnesses keeps them from realizing they need intervention and support," is a dangerous misunderstanding of how mental illness impacts so many people who bed down in public places, but his administration has deployed it in ways that line-up with the larger Broken Windows effort to get homeless people out of sight. Indeed, the Mayor's involuntary removal plan is far less a way to "help" people with severe mental illness than it is another justification to sweep homeless people out of sight as a way to reduce "the feeling of disorder," even if that simply means churning people through hospital ER's and harassing them to leave a subway car.

I. Recommendations

City Council should carefully scrutinize and reject the Mayor's involuntary removal initiative. Instead of focusing on symptoms of systemic, complex problems, we must try to address the root causes. Mobilization for Justice makes the following recommendations:

A. Broken Windows theory should be challenged by City Council at every turn. City Council has an opportunity to push the Mayor's office to cease implementing a baseless theory that has harmed so many Black and brown New Yorkers, in large part by targeting so-called "quality of life" offenses. As the guiding light of each of the Mayor's initiatives toward public homelessness, including the newly announced involuntary removal policy, Broken Windows will lead to the criminalization of many more – mostly Black and brown – homeless New Yorkers.

B. Sweeps must be ended. The Mayor's mental health initiative is the third sweep-centered initiative of his administration – the first two being the Subway Safety Plan and the aboveground encampments initiative, respectively. Sweeps cause vulnerable homeless individuals to be constantly pushed from place to place, often making their day to day

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[58] N Badre et al., "*Coercion and the Critical Psychiatrist,"* in S. Steingard (ed.), *Critical Psychiatry.* Switzerland: Springer, 2018.

[59] Safia Samee Ali and Tom Winter, "New York City will involuntarily hospitalize more mentally ill people under new plan." *NBC News*, November 29, 2022, https://www.nbcnews.com/news/us-news/new-york-city-will-involuntarily-hospitalize-mentally-ill-people-new-p-rcna59293.

lives harder. With this comes disruptions to accessing services, increased hypervigilance, and traumatic experiences of having their sole possessions tossed in the trash by municipal workers.

C. **Outreach teams and clinicians should provide support and resource access**. The Mayor's use of homeless outreach teams has increasingly involved frontline workers in the Broken Windows effort to move homeless people out of public space, regardless of where they go. This has the impact of harming the relations of outreach workers with homeless individuals, who sometimes come to refer to them as the "outreach police." Clinicians, whose job it should be to assess and support those they interact with, are instead being tasked with using poverty and surface-level assessments to justify removing homeless people, who may suffer from serious mental illness, out of public places.

D. **The supportive housing systems must be embraced and reformed**. The supportive housing systems in New York City have a lot of promise, but they often fail to live up to it. For example, providers are granted incredible latitude in how they treat applicants and tenants, even if it is in violation of applicable anti-discrimination law. Rather than embrace the evidence-based 'Housing First' approach, New York City has embraced a 'shelter-first' approach, where getting into a supportive housing unit is predicated on going into municipal shelters, which many find unsafe or unhelpful. Those individuals who do get an application completed and are lucky enough to get an interview with a provider, often find that they are asked invasive questions and can be denied for any reason the provider wants. City government must reform the front-end of the supportive housing system so that it meets the needs of applicants, particularly those who are currently most likely to be rejected. Additionally, there must be considerable oversight over the treatment of tenants in supportive housing and the way that supportive housing providers rely on evictions across the system.

E. **Voluntary Assertive Community Treatment and Intensive Mobile Treatment resources must be increased.** City-funded ACT and IMT teams that are based on voluntary engagement can be life changing for homeless individuals who struggle with the maze of accessing medical and mental health care in New York City. Unfortunately, these resources are in scarce supply, and are increasingly being aligned with policing. Funding should be prioritized for expanding them significantly, without also involving the presence of police.

Conclusion

Mobilization for Justice thanks the committees for holding a hearing on this important topic. We are committed to helping individuals in New York City who suffer from severe mental illness to access the care they need. Unfortunately, as discussed above, the Mayor's plan is a step in the opposite direction. We look forward to working with the Council to recenter the needs and perspectives of individuals with serious mental illness and advocates fighting for them in these conversations.

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NASW NEW YORK CITY CHAPTER
National Association of Social Workers

NATIONAL ASSOCIATION OF SOCIAL WORKERS- NEW YORK CITY CHAPTER (NASW-NYC)

TESTIMONY TO THE NEW YORK CITY COUNCIL

COMMITTEE ON MENTAL HEALTH, DISABILITIES, AND ADDICTIONS

OVERSIGHT- MENTAL HEALTH INVOLUNARY REMOVALS - MAYOR ADAMS' RECENTLY ANNOUNCED PLAN

February 6th, 2023

Thank you for the opportunity extended to the National Association of Social Workers-New York City Chapter (NASW-NYC), to provide written testimony on Mayor Adam's Involuntary Removal and Hospitalization plan. This is a timely discussion and is of particular interest to NASW-NYC as ***social workers remain among the largest providers of mental health services in the country***. Additionally, in the context of reviewing the Mayor's plan, as well as our keen awareness of the innumerable fractures in NYC's mental health systems of care, NASW-NYC believes it necessary to provide a well-rounded description of the larger issues impacting the mental health sector (low pay, inequality, and a significant history of underfunding), as these realities directly impact the feasibility of the Mayor's plan.

My name is Dr. Claire Green-Forde and I currently serve as the Executive Director for the National Association of Social Workers, NYC Chapter. The National Association of Social Workers (NASW) is the largest membership organization of professional social workers in the country, with over 110,000 members across 55 chapters representing every state in the Union, as well as Washington, D.C., Puerto Rico, Guam, and the U.S. Virgin Islands. The National Association of Social Workers-New York City Chapter, is one of the largest chapters in the association and represents approximately 5,000 members in the New York Metropolitan area. The chapter also advocates on behalf of the over 23,000+ registered social workers in the NYC area regardless of their membership status. The profession of social work largely concerns itself with advocating for social and racial justice, health equity, and empowering those who are marginalized and oppressed.

Concerns: Exclusion and Bias

In November of 2022, along with the rest of NYC, the National Association of Social Workers-New York City Chapter (NASW-NYC) learned of the Mayor's plan to involuntarily hospitalize people who may be unhoused and assumed to be mentally ill. We read the New York Times (NYT) article titled "New York City to Remove Mentally Ill People from Streets Against their Will" and we were immediately concerned. We took time to review the available plan, however this left us with more questions than answers, and more worry than comfort. Then and now, NASW-NYC has concerns regarding the plan, the stereotypes, overreach of power, the limited insight into the true challenges in the mental healthcare sector, and the biases that would undoubtedly spur the erroneous stereotypes about those living with mental health needs and those who are unhoused. We are also very concerned that the rhetoric around this plan and subsequent details regarding how it is to be carried out, would disproportionately impact people of the global majority and other marginalized groups. Moreover, the lack of collaboration and transparency gives us deeper pause. ***Why is it that a plan which purports to address the mental health needs of New Yorkers, was developed without including the voice and lens of NYC social workers? NASW-NYC is the largest professional social work organization in New York City and yet, despite our offers of collaboration, we have yet to be invited to the table.***

The referenced NYT article opens:

> "Acting to address 'a crisis we see all around us' toward the end of a year that has seen a string of high-profile crimes involving homeless people, Mayor Eric Adams announced a major push… to remove people with severe, untreated mental illness from the city's streets and subways". Mr. Adams, who has made clearing homeless encampments a priority since taking office in January, said the effort would require involuntarily hospitalizing people who were a danger to themselves, ***even if they posed no risk of harm to others***, arguing the city had a 'moral obligation' to help them."

Based on the article as well as additional information that NASW-NYC has reviewed in the past few weeks, it appears that the task of determining whether someone has a serious mental illness (SMI), is experiencing a psychiatric emergency, or is a danger to themselves, will be left to the New York City Police Department (NYPD), Emergency Medical Service (EMS) professionals, and other first responders. NASW-NYC asserts that **it is unconscionable to do so as the plan places an unfair and undue burden on first responders who are not trained to assess or evaluate mental health needs**. This approach also puts the professional well-being of first responders at risk if they are expected to operate outside of their scope of training and practice***. Social workers and other mental health practitioners are highly trained behavioral health specialists and require years of specialized education***, training/clinical internship hours, extensive experience, and successfully passing national licensure exams, to be credentialed. Expecting police officers and other first responders to reasonably recognize, assess, and make decisions about SMI when they don't have the relevant experience and training to do so, is dangerous and places communities at risk. There have been many incidences of people experiencing serious mental illness or a psychiatric crisis being killed when police respond to calls. How many more people need to be harmed or die unnecessarily before we learn from the errors of this approach? How many more families and communities will be left traumatized before we stop doing the same thing and expecting a different result? A one day, or perhaps even a two week course on mental health needs, does not make someone competent or capable of assessing SMI, risk, or mental health needs. What it does is create pathways for assumptions, stereotypes, prejudice, bias, and harm.

Social Workers: An undervalued solution to NYC's Mental Health Needs

NASW-NYC understand that NYC's leadership must respond to the needs of the city, the safety concerns, and the myriad of challenges. We do not take lightly the severity and vastness of these needs, nor the challenges this administration and others have faced. We know it is not easy and this is why we again extend an offer of true partnership and expertise. Our awareness of these complexities is also why we would be remiss if we didn't speak to a significant and growing concern that is impacting the mental health infrastructure in NYC and makes the plan untenable.

Over the past several months, we've continued to experience the impact of the mental health crisis and have experienced the demand for more social workers and other mental health providers. Countless articles have been published, including an article in May of 2022 by the Daily News titled NYC's Mental Health Crisis Spans Far and Wide with No End in Sight. We've read the reports of extremely long wait lists for services and understaffing in hospitals and community based clinics, listened to the stories of those who are living with mental health needs or have loved ones who are in need, and witnessed the harmful impact of untreated mental health conditions. Social workers know these factors existed long before COVID-19. Mental Health is one of the leading causes of disability world-wide and an estimated 1 in 5 New Yorkers has symptoms of a mental health condition. Despite the awareness that there is a need for mental health services, what we also experience are alarmist sentiments shouting that we don't have enough mental health workers, without NYC's government and leaders truly being willing to reflect on, and adequately respond to the root cause(s).

The current mental and social health needs of NYC are certainly not new or unique. Social workers are uniquely positioned and trained to address a wide range of biopsychosocial needs impacting individuals, families, and communities. Among countless specialty and practice areas, social workers are trained in advocacy, community organizing, behavioral health, and research. Each day, social workers help thousands of individuals and families address a myriad of needs, including trauma, housing insecurity, criminal and juvenile justice involvement, child welfare, death and dying, chronic illnesses, and severe mental illness. Social workers are incredible and work strategically to support and ungird many of the fractures in our systems of care. ***Despite these efforts, and the tremendous debt of gratitude owed to the individuals who make up this profession, social workers are not valued and are tired.*** Social workers are tired of being undervalued. Tired of being underpaid for the skills and education. Tired of extremely high caseloads. Tired of being asked to "do more with less". Tired of extremely high debt to income ratios in NYC. Tired of sacrificing their well-being, family time, and life goals, to support systems in NYC that don't support or value them. We are tired of being abused, unvalued, and ignored.

Many behavioral health professionals, including social workers in NYC, are making the decision not to work in certain sectors or organizations. They are leaving for other industries where they are offered competitive salaries, don't need to work multiple jobs to survive in NYC, and where they can have life-work balance to support their own wellness. **Social Workers are mental health professionals and are trained to respond to NYC's mental health needs.** ***When will New York City's leaders and representatives work to fairly compensate and support those best trained to respond to the Mental Health needs of New Yorkers? Social Workers have waited decades for pay equity and fairness; enough is enough.*** The National Association of Social Workers - New York City Chapter has long advocated for pay equity as well as higher compensation for social workers, commeasure with the level of education, training, and skill required to practice as a social

worker. NASW-NYC speaks to many people considering entering the profession, those already in the profession, and those leaving. We are often asked, ***"Why would anyone want to sacrifice so much, to be overworked in a high stress, low respected, and low paid field"?***

If this administration truly wants to address NYC's mental health needs, it's imperative that the administration works collaboratively with social workers and seeks to root out inequities. It's necessary that NYC's leaders tangibly demonstrate the same value and respect to social workers that other sectors and departments in NYC are shown through the funding, loan forgiveness, incentives, and professional development opportunities those sectors consistently receive when budgets are allocated. New York City leaders, and agencies cannot continue to devalue and underfund an entire professional sector, yet call on its best, brightest, and most skilled in times crisis. It is unconscionable for New York City's political, human service, and health care leaders to continue this system of oppression and exploitation, yet ask social workers to help support and heal the traumas of NYC's residents.

A Fractured Plan to Address NYC's Mental Health Needs

The needs of New Yorkers are complex and require thoughtful, holistic responses; we all have a fundamental right to be safe. New York City continues to grapple with several crises related to immigration, humanitarian needs, economic hardships, poverty, housing insecurity, high cost of living, criminal justice, and mental health. NASW-NYC is keenly aware that there has been mounting political and social pressure to respond to the increase in crimes, encampments on the streets, and the financial hardships impacting countless families and businesses. NASW-NYC understands that people are demanding changes and we agree that changes need to be made. ***NASW-NYC calls for changes that center health equity, racial and social justice, the right to self-determination, and the dignity and worth of all individuals.*** Social workers are among the largest providers of mental health services in the country, including New York. Plans that will undoubtedly impact those already at risk, while minimizing or ignoring the specialization and training required to adequately address NYC's mental health needs, adds to NASW-NYC's growing concern. Further adding to our concerns is **the ongoing rhetoric that people who live with a mental illness are inherently violent —this false rhetoric must stop!** Are there people who live with a mental illness who may also happen to commit acts of violence? Absolutely! However; ***there are vastly more people who are not living with a serious mental illness (SMI), who commit violent crimes***. We must stop conflating mental illness with violence. There are countless academic articles and stories calling out the tendency to scapegoat mental illness; these stories highlight the fact that people who are mentally ill are typically the victims of crime, rather than the perpetrators. In order to positively move towards a path of understanding and comprehensive response, NYC leaders and residents must be properly educated about mental health. ***It is dangerous to conflate people who are living with mental health needs, people who are having a psychiatric emergency, people who are committing crimes, and people who are being targeted, scapegoated, and criminalized because of poverty.*** These are not the same and should not be treated as such.

As more information has been released since the initial announcement of this plan in late November 2022, NASW-NYC now takes a firm position and cannot support the plan in its current form. We acknowledge that there are many elements related to its development that we are not privy to yet, based on what is publically available at this time, we have grave concerns. After a full review of Mayor Adams' Psychiatric Crisis Care Legislative Agenda, and with a profound understanding that this is a difficult process, there are several areas for concern, including that the plan does not appear to be as comprehensive as would be expected. Additionally, it does appear to take into consideration the realities of the current mental health landscape and the deep fractures in NYC's systems of care. This plan does not appear to have a lens of true inclusivity; it is critically important to include the perspectives and voices of people with direct lived and professional experiences when developing plans to address mental and social health needs. Social workers who directly engage with, assess, and treat people living with mental health needs, do not appear to have been included at all or substantially in the development of this plan. The plan contains several gaps, including ones that may potentially place social workers and other mental health service providers in ethical dilemmas or create conflicts with their professional values and established code of ethics. Highly specialized and trained voices, including the social work lens, are necessary and should always be included when developing plans with such deep implications. ***The social work lens is critical – mental health needs in NYC and beyond are equally related to racial and social justice, as they are to access to quality care and health equity.*** NASW-NYC, social workers seek to support initiatives that are comprehensive, inclusive, culturally respectful, and designed with the interest(s) of those in need. We are keenly aware that adequately supporting the mental health needs of NYC is a huge undertaking. Doing so would require significant financial investment, truly assessing the current mental health infrastructure and making substantial changes, and necessitates a commitment from NYC leaders and community stakeholders to include those best positioned to address those needs in the decision making process.

NASW-NYC would be remiss if we did not acknowledge the deeply fractured and bifurcated system of care in New York City's mental health system. As an example, a recent article re-published by the Brooklyn Daily Eagle titled "Public Schools are NYC's main Youth Mental Health System. Where Kids land Often Depends on what Their Parents Can Pay" squarely highlights the bifurcation in mental health service provision as well as the inadequacies, impacting NYC youth. The Mayor's plan failed to acknowledge the significant backlog and challenges with the courts and Kendra's Law/ Assisted Outpatient Treatment (AOT) programs in New York. It did not deeply acknowledge that our hospitals, community based organizations and clinics are woefully underfunded and understaffed, nor did it recognize that clients are forced to navigate the impact of pervasive underfunding and structural inequalities in the social and health care sectors. The plan didn't acknowledge that clinicians are leaving the industry because of a lack of support, the ongoing refusal to fairly compensate social workers for their skills, training and education, high caseloads, and burnout.

There is a reason why there has been so much outcry and backlash regarding this plan. NASW-NYC maintains that if the plan continues to be that there is a desire to involuntarily admit people to hospitals "**even if they posed no risk of harm to others**", our questions to the Mayor and the administration remain as follows:

1. What are your **immediate** plans to adequately staff and fund the hospitals and systems of care?
2. How and when will you staff the courts, revamp the AOT process, and thoroughly educate that system around mental health?
3. What is the plan to support discharge planning in hospitals and fund the community based organizations receiving referrals?
4. What is the plan to staff and fund the housing service networks who are a significant part of the aftercare network?
5. What plans have you created to increase the behavioral health provider pathway and what incentives will you provide to encourage its growth? Will loan forgiveness and fair compensation be incentives you consider?
6. What is the plan to support uninsured and insured clients as insurance companies will more than likely deny lengthy inpatient stays as well as evaluations and treatment that they deem unnecessary?
7. How will you ensure racial and social justice, root out biases in these processes, and hold the system and people accountable to be anti-racist and anti-oppressive?
8. Are you asking providers to fabricate diagnoses and provide treatment against people's will? If yes, is the intention simply to move people who are unhoused off the street so that they don't highlight the inequities that exist, particularly as it relates to housing, poverty, social, and racial discrimination in NYC?

Until these questions can be answered truthfully and comprehensively by the current mayoral administration, NASW-NYC cannot in good faith, support this plan in its current form; it goes against the core values of the social work profession. NASW-NYC continues to express our willingness and readiness to partner with the current Mayoral administration to thoughtfully address many of the bio-psycho-social needs impacting NYC.

Thank you again for the opportunity to provide testimony regarding the Mayor's plan. We appreciate the opportunity to provide more context as well as center the social work lens in this multilayered issue. We remain hopeful that the Adams administration, elected officials, and other stakeholders will be willing to extend the offer of partnership to NASW-NYC and the social work community, in better service to New York City.

In closing, I leave you with this final thought: ***Humans, our experiences, and the conditions that shape us are beautifully and painfully complex. The experiences we have, including our mental health needs, should be treated with care, respect, inclusiveness, thoughtfulness, and dignity. Above all, we must approach human needs through a lens of racial and social justice to ensure that we center cultural humility and health equity***.

With appreciation ,

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Testimony of Carolyn Strudwick, Associate Vice President
Safe Horizon Streetwork Project

Committee on Public Safety
Hon. Kamillah Hanks, Chair

Committee on Mental Health, Disabilities, and Addiction
Hon. Linda Lee, Chair

Committee on Fire and Emergency Management
Hon. Joann Ariola, Chair

Committee on Hospitals
Hon. Mercedes Narcisse, Chair

Safe Horizon's Testimony on Mental Health Involuntary Removals and Mayor Adams' Plan

2.6.2023

Good afternoon and thank you for the opportunity to provide testimony before the Committees on Public Safety; Mental Health, Disabilities, and Addiction; Fire and Emergency Management; and Hospitals. My name is Carolyn Strudwick, and I am Associate Vice President of Streetwork Project at Safe Horizon, the nation's largest non-profit victim services organization. Safe Horizon offers a client-centered, trauma-informed response to 250,000 New Yorkers each year who have experienced violence or abuse. We are increasingly using a lens of racial equity to guide our work with clients, with each other, and in developing the positions we hold.

For more than 40 years, Safe Horizon has existed to support victims of violence and abuse. We have always been an organization that recognizes and helps survivors to heal from many types of violence - intimate partner violence, family violence, sexual violence, and other interconnected forms of violence and harm. We have staff and programs in every borough, in every community across New York City, including at every police precinct, every Family Justice Center, and every Child Advocacy Center. Throughout our history, we have partnered with law enforcement. Through those partnerships, we have worked with police officers and prosecutors to keep victims safe and hold those who cause harm accountable. We have advocated for policy and practice changes to make these systems more responsive to our clients. And we have prided ourselves on bringing greater respect, compassion, and self-determination to survivors involved in the criminal justice process through our client-centered approach to advocacy.

Yet the reality is that our law enforcement partners have also caused harm, and we have not done all we could to stop that harm, or even name it for what it is - racism. Systemic and sometimes individual racism. Black and brown people, especially men and transgender women, are far more likely to be killed by the police and to experience violence at the hands of police officers. And they face bias and inequity in every aspect of the criminal justice system. Our clients and our staff have been telling us about these realities for years. Safe Horizon's mission is to provide support, prevent violence, and promote justice for victims of crime and abuse, their families, and communities. We believe that confronting and ultimately dismantling systemic racism is necessary to fulfilling our mission because systemic racism denies justice and is rooted in violence.

Too many of the victims and survivors we serve, and too many of our colleagues and loved ones have had encounters with police officers that were dehumanizing. We know that these experiences are a profound barrier to safety and healing. It is because of this history and this experience that we have major concerns with Mayor Adams' recently announced plans to have police officers involuntarily remove and hospitalize New Yorkers they deem too mentally ill to care for themselves, even if they pose no threat to others. This plan is dangerous and will very likely lead to further violence.

The Administration's plan directs resources into a failed strategy. The Administration is approaching the homelessness crisis with the mindset that unhoused New Yorkers are refusing support rather than seeing and understanding that our current systems responses are vastly inadequate. What unhoused New Yorkers need is not an expanded police response but a massive investment in housing and long-term treatment and care.

In my testimony today, I will focus on how this plan fails Runaway and Homeless Youth (RHY) specifically. Our systems already generally view RHY suspiciously and see them as

troublemakers, not as fellow full human beings deserving of support. RHY and our community of service providers have faced unnecessary obstacles for far too long, including a dearth of safe short-term shelter and long-term housing options. To start, we have been collectively advocating for additional Safe Haven and stabilization beds for many years. These beds, which are operated by DHS, especially benefit unhoused people with mental illness. Unhoused New Yorkers are connected to Safe Haven and stabilization beds by DHS outreach teams, but until very recently, no youth services provider was able to make these referrals directly. RHY are generally not seen as homeless New Yorkers in need of housing but as dangerous or misbehaving young people "up to no good." Because young people are generally not seen, approached, or supported by DHS-funded outreach teams, they are not connected to many of the services for which they are eligible.

We know about these gaps in DHS outreach because Streetwork Project holds a separate DYCD-funded outreach contract covering RHY outreach across all 5 boroughs. Our Streetwork outreach teams go out at night and target areas where youth are known to congregate. We provide snacks, warm blankets, other essential items, and information about drop-in services and shelter resources. When a young person needs help getting to safety, we provide transportation. Under this DYCD outreach contract, two teams of two people - the Northern Team covering the Bronx, Queens, and Manhattan above 59th Street and the Southern team covering Brooklyn, Staten Island, and Manhattan below 59th Street - conduct outreach 6 nights per week, from 7pm - 2am. DYCD's resources are not comparable to DHS's resources. There are vastly more DHS-contracted outreach teams composed of case managers and mental health providers. Our outreach workers provide information to young people about Safe Havens and stabilization beds and connect them to our Streetwork Drop-In Centers, where our staff can now refer our clients to these critical supports.

I say "now" because during the pandemic, the City finally expanded access to Safe Havens and stabilization beds. When we were finally allowed to provide direct referrals to Safe Havens and stabilization beds, we were able to place nearly 100 young people. We are also deeply appreciative that additional beds were brought online during the pandemic, but we need more to meet the demand. We continue to face an inadequate supply of Safe Haven and stabilization beds. And of the beds that are currently online, none are specific to young adults and RHY, none are specific to LGBTQ+ folks, and very few are specific to women. We know the young people coming to Streetwork. We know they are seeking safe shelter, but the supply does not meet the demand. The young folks we work with have experienced trauma and violence, and many have PTSD. The violence and abuse they experienced often resulted from shared living situations; for them, shared sleeping areas are dangerous and scary. This is why the private room model is critical. The Safe Haven and stabilization bed models work. That is why expanded access has been a game changer especially during the pandemic. Unfortunately, there are currently long waitlists for private rooms. Expanding access even further, rather than implementing this recent problematic removal plan, should be a priority for the Administration. People who are on waiting lists for appropriate shelters are not refusing to enter shelter.

In our experience, RHY become chronically homeless when they age out of youth shelter, are banned from specific RHY programs, or enter the DHS system, are assigned to a DHS mental health shelter, and then decide that the street feels like a safer option to them than that shelter. Generally, a young person might be banned from a program as a result of behavioral issues, which are often connected to mental health needs. DYCD youth shelters and our community of RHY

programs are not funded to provide the level of clinical services and mental health treatment that many homeless youth need. DHS has mental health shelters, but the system does not have any mental health shelters designed specifically for young people. RHY can enter adult shelters, but we know that young folks often feel unsafe being housed with adults. We have heard from clients that they feel safer living on the street. And the reality is that when someone leaves the shelter they were assigned to, they will only ever be referred back to that shelter they left. This means that the unhoused young person must choose between living on the street and returning to the shelter they find unsafe. NYC does not currently have a mental health shelter for young adults, even though there is a demonstrated need for this type of shelter.

Another issue with the Administration's plan is the reality that our current mental health system is itself in crisis. At Streetwork, we have clients who **are** seeking mental health services and supports. Unfortunately, the mental health system has been plagued by underinvestment and cannot currently meet the demand. The Administration's plan is to involuntarily hospitalize unhoused New Yorkers. People who are hospitalized are usually discharged from the hospital within 24 hours back onto the street with a referral to an outpatient program. These programs are not accessible when street homeless. As others are testifying, this system was already lacking before the pandemic, but now even fewer emergency psych beds exist for those who would benefit. Forcefully hospitalizing folks and cycling them through the system will do more harm than good. In our experience, voluntary programs are more effective and generally much cheaper. We should be funding and expanding voluntary services rather than traumatizing already traumatized people.

Lastly, we have major concerns with the Administration's plan to use police officers to engage with unhoused folks. To many of our clients, the NYPD does not represent safety. Many of our clients have experienced violence at the hands of the police. Even if an individual officer is kind and caring to our clients, the uniform itself may represent danger and trauma to a client who previously experienced police violence. We fear that more interactions between police officers and unhoused New Yorkers will lead to an increase in violence and death. Our Streetwork team has had several negative interactions with police officers. Once, when one of our clients was suicidal, we called 911 for assistance. Our staff were sitting with her and engaging her, and she was not a danger to anyone. Police arrived in riot gear and immediately pinned the client to the ground. Officers assaulted our client, used transphobic slurs, and misgendered her, and our staff had to deescalate the situation. Afterwards, the client stopped engaging with our programming as it no longer felt safe for her after this violent incident. Another Streetwork client, David Felix, who had a history of mental illness and lived in supportive housing, was tragically killed by the police.

We know that the NYPD's budget has continued to grow even when crime rates dropped dramatically over the last three decades, and that officers have been asked to respond to an ever-increasing number of societal issues that are better addressed by mental health clinicians, social workers, and outreach workers. At the same time, our city, state, and federal governments have not prioritized investing in programming that more effectively addresses underlying issues and root causes of violence and trauma. We are seeing this same dynamic playing out again – the City is turning to the police to address NYC's overlapping homelessness and mental health crises rather than prioritizing funding for housing and mental health.

Safe Horizon supports non-police responses to New Yorkers experiencing homelessness and mental health crises. Transferring these responsibilities would allow the police department to focus on incidents of violence where their presence is needed, while reducing the likelihood of harm to vulnerable New Yorkers. The Administration's plan charges NYPD to make assessments that require extensive training and expertise on mental health. We do not believe that we need to or should turn to law enforcement to respond to every incident of an individual in mental health crisis and/or substance use crisis. In most cases, an outreach team consisting of peers and behavioral health specialists can help safely stabilize the individual and more effectively connect them with voluntary services and care. Of course, this also requires that the City sustainably invest not just in outreach but in the community-based services, mental health treatment programs, and housing options that New Yorkers in crisis need to heal.

Ultimately, unhoused New Yorkers need quality, safe, affordable housing and accessible mental health services. That is where we should be investing our resources. Thank you for the opportunity to testify.

City Council Committee on Mental Health, Disabilities and Addiction Jointly with the Committee on Fire and Emergency Management, the Committee on Public Safety, and the Committee on Hospitals
February 6, 2023

Good morning Chairs and distinguished members of the council. My name is Amy Dorin, President, and CEO of the Coalition for Behavioral Health. The Coalition for Behavioral Health agrees with Mayor Adams that people with mental illness who are homeless deserve better than living untreated and unsheltered on New York City's streets and subways. As the advocacy and policy organization for over 100 New York behavioral health provider organizations, however, The Coalition strongly objects to the Mayor's proposed solution to this problem. Unhoused people with mental illness are the result of inadequate housing and mental health care. The system as whole has failed to address their needs for decades. It's time we rethink how New York City approaches such problems, and not just do the things we've tried over and over again without success.

Having police take homeless people they suspect of having a mental illness (many will be Black and Hispanic), who are may not be at imminent risk of harm to themselves or others, to the hospital against their wishes, will unnecessarily traumatize them. Even if the evaluation shows involuntary hospitalization is warranted, NYC's desperate lack of inpatient psychiatric capacity and incomplete continuum of services guarantees that they are off the streets for only a few hours, days or weeks. When they leave the hospital, most will end up right back on the street or in shelters without ongoing mental health care to maintain any progress made during their hospitalization. They will also be much more wary, taking greater care to hide from street outreach teams and law enforcement to avoid once again being forcibly hospitalized.

The paperwork and patience required to access compassionate care and an affordable place to live with services is simply beyond the capacity of most of the people we pass in our streets and subways. We therefore urge Mayor Adams and Governor Hochul to immediately implement a more effective approach that builds trust with vulnerable New Yorkers who need our help and facilitates easy access to essential services. The governor's State of the State address included some proposals our coalition's members have long supported:

- Expand the supply of supportive housing that combines homes with behavioral health care.
- Develop more intensive, community-based treatment, such as assertive community treatment and intensive mobile treatment.

Other proposals not in the State of the State address that the city and state should act on immediately:

• Streamline City processes that keep people from accessing the services they need. It can take many months to access supportive housing and intensive treatment, with many homeless people giving up after long delays.

• Expand the City's mobile crisis capacity that enables people in psychiatric crisis to access support specific for their needs. Enhanced federal support is available, which makes this model exceptionally cost effective.

• Increase outpatient treatment capacity, especially the new federally developed Certified Community Behavioral Health Clinic (CCBHC) model. NYS has an opportunity to expand the number of CCBHCs receiving enhanced payments that support comprehensive care. Access to on-demand, person-centered, evidence-based and trauma-informed mental health treatment can prevent people from getting so sick they end up on the street.

• Create and support additional psychosocial rehabilitation services to help people with serious mental illnesses remain engaged in care and working toward lives of productivity and dignity

• Add on-site mental health care to the homeless shelter system. Only 71 of 554 New York City homeless shelters have on-site mental health services, including only one of the 55 domestic violence shelters. This is an immediate, direct and cost-effective way to increase access to mental health care for people who are homeless.

• Address the workforce crisis that is preventing community behavioral health providers from expanding their service capacity

This crisis is a result of decades of failure by successive administrations to develop and implement a plan to scale up the services that we know work to end homelessness, engage people with severe mental illness in treatment, and address the economic and health care access disparities faced by Black and Latino New Yorkers, who are disproportionately represented in the city's homeless population.

The mayor's proposal will cost the city heavily. In addition to the training and other law enforcement costs, there will be significant costs associated with increased emergency medical and hospital services, civil rights lawsuits and incarceration, which will inevitably result from police interactions. These dollars would be better spent on comprehensive solutions that work to transform the behavioral health and homeless services system to positively change the lives of people who are homeless and have a serious mental illness.

We agree with Mayor Adams that “it is not acceptable for us to see someone who clearly needs help and walk past them.” He has an historic opportunity to forge a better, more thoughtful and sustainable approach than past Mayors, who failed to create a comprehensive plan and fund the housing and healthcare that will address the problem at its roots. We urge Mayor Adams to collaborate with NYC’s mental health professionals and community agencies to develop a thoughtful and comprehensive plan to transform lives, while reducing the numbers of people forced to live in our public spaces because they lack a better option.

Thank you for the opportunity to submit this testimony today.

THE LEGAL AID SOCIETY

Justice in Every Borough.

The Legal Aid Society Testimony Regarding the City of New York's Mental Health Involuntary Removal Policy

Submitted to the Committees on Mental Health, Disabilities and Addiction; Fire and Emergency Management; Hospitals; and Public Safety

February 9, 2023

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The Legal Aid Society applauds the Committees for their oversight of the City of New York's recently announced Mental Health Involuntary Removal Policy.

Mayor Adams would have us believe that the problem of homeless people with mental illness being unable to care for their basic needs is the product of individual neglect and bad choices. In announcing the Mental Health Involuntary Removal policy, he said, "It is not acceptable for us to see someone who clearly needs help and walk past."[i] He has said that people who urgently need treatment "refuse[] it when offered."[ii] Those statements echo the now-discredited "culture of poverty" discourse that blames individual people for system failures. As in the past, this type of rhetoric obscures how the government is furthering discrimination and racial injustice.

The City is responsible for providing a comprehensive system of community-based care and treatment for people with disabilities.[iii] Under the Americans with Disabilities Act and the Rehabilitation Act of 1973, the City is required to administer this system in a manner that enables individuals with disabilities to be accommodated in the most integrated setting appropriate to their needs.[iv]

Federal disability rights law recognizes that unnecessary institutionalization is discrimination.[v] Relegating people with mental illness to hospitals or other institutions for their treatment needs when they can be accommodated in the community is discriminatory.

Most people with mental illness can be served in the community. What that looks like is people living in safe, community-based housing, where they can pursue their own goals, exercise choice, be decision-makers, and maintain relationships with peers and loved ones. It looks like people having individualized supports to help them navigate systems and obtain care.

In the words of a Legal Aid client, "housing keeps the body and soul together." Our client lived in a city shelter for fourteen months. He also experienced involuntary commitment in a psychiatric ward for an entire summer—an experience he described as a traumatizing and dangerous. He said he witnessed things he "cannot un-see." By contrast, housing offers stability and enables him to "carry on with life."

Our Civil and Criminal Defense practices represent many other individuals who are not in integrated community-based housing. The Mayor's Office estimates that approximately 40% of the homeless shelter population has mental illness.[vi] The State estimates that 4,000 individuals with mental illness are street homeless in the City.[vii]

The City's response to the problem of people with mental illness with unmet needs is to effectively double down on this crisis. Rather than provide services in integrated settings as it is required to do, the City's directive will sweep people into hospitals, even when those individuals can and should be accommodated in the community. This policy violates federal disability rights law.

Our clients experience the consequences of the City's failure to develop an effective system of community-based mental health services every day. They rotate through a revolving

door of institutions—jails, homeless shelters, and hospitals—rarely receiving the treatment, housing, and supportive services they need. The City's mental health system lacks a) adequate outpatient services, b) residential treatment programs, including for people with co-occurring mental health and substance use treatment needs, c) housing programs, and d) supportive services. These deficiencies have a devastating impact on our clients.

First, people with mental illness spend longer periods in jail because DAs and judges reject proffered release plans until housing or a residential program is secured. Our attorneys move mountains to find scarce housing to free our clients from abysmal jail conditions. In cases where no objection to release is made, the Department of Correction routinely discharges our clients to homeless shelters that are inaccessible, unsafe, and ill-equipped to provide mental health supports. There, our clients languish for months as their applications for housing and supportive services wind their way slowly through a system that is overly bureaucratic and, in any case, lacks bed capacity for all those in need. And although many individuals with serious mental illness need a high-level of support to manage their day-to-day needs and remain healthy,[viii] few receive it. Instead, many of our clients are forced to navigate various confusing systems to obtain benefits and pursue housing opportunities, with very little assistance from City workers. The Mayor's budget proposal to further cut social services will exacerbate these problems.

Our clients face enormous difficulty obtaining adequate care and treatment. Often, available treatment tends towards the extremes—either civil commitment or basic outpatient services—with very little in between. When our clients deteriorate and go to hospitals, they are often swiftly released without a plan for follow-up care or housing. For example, many Legal Aid Society clients arrive at a City hospital from Rikers Island after having been found unfit to stand trial. Despite having significant psychiatric treatment needs, hospitals offer no treatment or discharge planning, because they do not meet the civil commitment standard.

Many individuals with serious mental illness could be successful and in recovery if they had, among other things, stable housing; clinicians that provided trauma-informed care; peer supports; and intensive care coordination. One Legal Aid client who decompensated severely, leading to arrest and incarceration, credited housing as giving him a "second chance." He first obtained a placement in an apartment treatment program. From there, he graduated to independent supportive housing, where he has been successful for over a decade.

The City must ensure that voluntary community-based services are available and accessible. It also must ensure that housing is adequately funded, so that there is sufficient capacity along the housing continuum. The City should maximize the State's proposed investments in mental health services and housing to improve coordination between providers, eliminate gaps in care, and reduce waiting lists for housing and services. Without such efforts, the City effectively condemns our clients to a vicious cycle of institutionalization. The City's Mental Health Involuntary Removals policy does nothing to break this cycle. It keeps it spinning instead.

We urge the Committees to require the Mayor's office, the NYPD, FDNY, and Health and Hospitals, which are involved in implementation of the new directive, to make public data

about the number of removals that are made *pursuant* to the directive. Each removal pursuant to the directive must be documented, with information that enables the public and the Committees to continue oversight. Such documentation should provide information including but not limited to a) the alleged basis for the removal, b) demographic information (age, race, ethnicity) about the individual subject to a removal, c) whether the individual was admitted for hospitalization, and if so, at which hospital, d) personnel involved in the removal, and e) neighborhood and location information indicating whether the individual was in a private dwelling or a public place, e.g., the street, park, or public transportation.

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[i] Transcript: Mayor Eric Adams Delivers Address on Mental Health Crisis in New York City and Holds Q-and-A, Nov. 29, 2022, *available at* https://www.nyc.gov/office-of-the-mayor/news/871-22/transcript-mayor-eric-adams-delivers-address-mental-health-crisis-new-york-city-holds (last visited Jan. 26, 2023).
[ii] *Id.*
[iii] N.Y. Mental Hygiene Law §§ 7.01, 41.13.
[iv] *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999); *Davis v. Shah*, 821 F.3d 231, 263 (2d Cir. 2016).
[v] *Olmstead*, 527 U.S. at 597.
[vi] City of New York, *Housing Our Neighbors: A Blueprint for Housing and Homelessness* at p. 52, *available at* https://www1.nyc.gov/assets/home/downloads/pdf/office-of-the-mayor/2022/Housing-Blueprint.pdf.
[vii] New York State Office of Mental Health, Safe Options Support (SOS) Program: CTI Teams, New York City, Request for Proposals, at p.3, https://omh.ny.gov/omhweb/rfp/2022/sos/sos_cti_rfp.pdf
[viii] One model of such support is Assertive Community Treatment or Forensic Assertive Community Treatment, which is a multi-disciplinary team of professionals, available 24/7, to provide care coordination. These teams meet with clients where they were, in the community. They provide direct assistance to an individual, supporting them in managing doctors' appointments, arranging for transportation, ensuring prescriptions are refilled, making sure benefits and entitlements are active, and being immediately available when crises arise. *See generally* New York State Office of Mental Health, Assertive Community Treatment, https://omh.ny.gov/omhweb/act/ (last visited Feb. 9. 2023). There are 65 ACT teams in the City, and these teams currently operate at 89% capacity. *See* Assertive Community Treatment (ACT), Location and Information for New York State ACT Teams, New York City, https://omh.ny.gov/omhweb/tableau/act.html (last visited Feb. 9, 2023).

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New York City Council
Oversight – Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan

February 6th, 2023

My name is Dr. Jeremy Kidd. I am an addiction psychiatrist at Columbia University and am submitting testimony today as president of the New York County Psychiatric Society (NYCPS), an organization representing over 1600 psychiatrists in NYC. Our members work in outpatient clinics, inpatient hospitals, emergency departments, jails, prisons, and homeless shelters.

We wish to voice our concerns about the Mayor's Mental Health Involuntary Removals directive. While we acknowledge that the housing and mental health crises in our city require immediate action, we believe that this directive inappropriately over-relies on the NYPD and does not adequately address the root causes of homelessness or untreated mental illness. This directive fails to address the shortage of safe, affordable, supported housing and the lack of outpatient mental health treatment. We are advocating for the Mayor to re-evaluate this policy and to consider reallocating resources to areas that will result in demonstrable benefit to unhoused people with mental illness. We hope that City Council will help provide much needed oversight in the following three areas:

1. NY State law already dictates that people can be admitted involuntarily to hospitals if they have a diagnosable psychiatric illness and are at risk of harming themselves or others *due to that illness*. However, when poverty and homelessness are the primary contributors to someone's inability to care for themselves, psychiatric hospitalization is not clinically warranted. The City Council can provide oversight to ensure that due process and civil rights are protected.

2. Inpatient psychiatric bed capacity in NYC is severely limited. This shortage was exacerbated during the COVID-19 pandemic as private hospitals converted psychiatric beds to medical and surgical units. In many cases, hospitals seized this opportunity to permanently close psychiatric inpatient units. Our members working in emergency departments report that patients who need psychiatric hospitalization frequently wait hours or even days for a bed. The 50 additional inpatient psychiatric beds the administration announced are woefully inadequate to meet this need. The City Council can help by tracking the impact of the Mayor's directive on emergency departments and wait-times for psychiatric hospitalization.

3. Unhoused people with mental illness need stable, affordable housing and access to community-based mental health care in a “housing first” model. Emergency detention and involuntary hospitalization provide neither of these. The current situation is the result of decades of deinstitutionalization and the unfulfilled promise that previously hospitalized individuals would receive access to robust outpatient services. Resources are required to increase supported and supportive housing and to expand the availability of ACT teams/FACT teams/IMT teams and Street Outreach teams. Another important focus is on prevention and early intervention programs like the OnTrackNY program, which provides comprehensive services (e.g., treatment, vocational support, educational support, housing assistance) to people with recent-onset psychosis. The goal of these programs is to prevent individuals with severe mental illness from becoming unhoused in the first place. The pre-pandemic shortage of psychiatrists has only gotten worse with many outpatient treatment programs unable to fill vacancies. City Council oversight can determine whether the Mayor’s directive has resulted in people gaining access to housing and outpatient care. We do not believe that it has or will.

In summary, we at the New York County Psychiatric Society (NYCPS) ask the City Council to ensure that the Mayor’s directive does not impede on the civil rights of unhoused individuals with mental illness and to monitor the impact of this directive on already crowded emergency rooms and overtaxed outpatient mental health services. We at NYCPS are happy to serve as a resource to the City Council and the Mayor’s Office in this process.

Thank you for your time and attention.
Sincerely,

Jeremy Kidd, MD, MPH
President

February 6, 2023

New York City Council
Joint Hearing by the Committee on Mental Health, Disabilities, and Addiction, the Committee on Hospitals, the Committee on Fire and Emergency Management, and the Committee on Public Safety
Re: Oversight -- Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan

Written Testimony of The Bronx Defenders
By: Siya Hegde (Housing Policy Counsel, Civil Action Practice), Rosa Jaffe-Geffner (Director of Social Work, Civil Action Practice), and Julia Solomons (Senior Policy Social Worker, Criminal Defense Practice)

The Bronx Defenders ("BxD")[1] thanks the Council's Committee on Mental Health, Disabilities, and Addiction, Committee on Hospitals, Committee on Fire and Emergency Management, and Committee on Public Safety for holding this important oversight hearing. Our testimony encompasses a holistic defender perspective to highlight our collective concerns around the Mayor's Involuntary Mental Health Directive and its far-reaching consequences on the communities we serve.

As holistic defenders, we are positioned to defend against structural, systemic failures of our legal and political systems as we see how certain policy agendas and legal system barriers trigger our clients' family separation, threats of eviction and displacement from homes, lack of access to essential support services, and violation of their civil liberties. We find the Mayor's Involuntary Mental Health Directive a glaring example of how our city's solution to addressing the longstanding gaps in our homelessness and mental health crises is one of community divestment rather than investment and urge for it to be rescinded immediately.

[1] BxD is a public defender non-profit that is radically transforming how people in the Bronx are represented in the legal system, and, in doing so, is transforming the system itself. Our staff of over 350 includes interdisciplinary teams made up of criminal, civil, immigration, and family defense attorneys, as well as social workers, benefits specialists, legal advocates, parent advocates, investigators, and team administrators, who collaborate to provide holistic advocacy to address the causes and consequences of law system involvement. Through this integrated, team-based structure, we have pioneered a groundbreaking, nationally-recognized model of representation we call holistic defense that achieves transformative outcomes for the people we represent. Each year, we defend more than 20,000 low-income Bronx residents in criminal, civil, family, and immigration cases, and reach thousands more through our community intake, youth mentoring, and outreach programs. Through impact litigation, policy advocacy, and community organizing, we push for systemic reform at the local, state, and national level. We take what we learn from the people we represent and communities that we work with and launch innovative programs designed to bring about real and lasting change.

I. The Mayor's Directive systematically triggers harmful, life-altering consequences on the lives of people of color as it serves a mechanism to criminalize poverty and homelessness and forces them into jails and hospitals.

In the Bronx, Black and Latine-identifying people of color have suffered decades of overpolicing and surveillance by law enforcement agents, and persistent racial and other forms of discrimination have undoubtedly contributed to these violent interventions. Rather than committing to addressing the unmet needs of unhoused New Yorkers, the Mayor's directive provides a new and troubling standard for law enforcement to assess an individual's mental capacities. In giving such untethered deference to these agents who are not skilled medical practitioners, the directive sets a dangerous precedent for public safety while reinforcing historic discriminatory measures that disproportionately affect people of color and people with disabilities.

In recent weeks, we have already seen some of the disparate, adverse consequences of this directive on Bronx residents and would like to uplift two scenarios. Both clients have given explicit permission for us to share details of their personal accounts with the Council.

Mr. A., a queer-identifying Black man with serious mental health conditions, was subjected to removal from his home and sent to a hospital against his will. Five police officers and three EMS staff crowded Mr. A's small, confined basement room after a family member called 9-1-1 stating that there had been a verbal dispute and that Mr. A was not taking his medication. Notably, this same family member is currently trying to evict Mr. A in Bronx Housing Court, and, thus, benefitted from having Mr. A leave the premises as quickly as possible. Although Mr. A presented calmly and repeatedly to the law enforcement and EMS personnel int the room, furthermore, having stated his intent to restart his medication with the telephonic assistance of his social worker, the police refused to leave the scene. Consequently, Mr. A was sent to the psychiatric emergency room, though he was released in less than 72 hours after being deemed ineligible for admittance. In the aftermath of his release, the treating psychologist on staff called what had taken place "unjust".

In another example that transpired in late January 2023, our client, Ms. P., who had underlying mental health diagnoses of post-traumatic stress disorder and depression, experienced a similarly violent and traumatic encounter with police officers and was hospitalized in a psychiatric facility without her consent. Responding to an alleged domestic incident in which Ms. P had been choked by her boyfriend and suffered a triggering reaction in the aftermath, police officers forcibly grabbed her, and pinned her to her bed—handcuffing her while she was half-naked—while EMS personnel injected her with what appeared to be a sedative. As she allegedly resisted arrest, verbally expressed her desire for treatment and therapy, and made expressly clear that she did not want to go to the hospital, she was eventually charged with assaulting an officer and an EMS personnel and detained on Rikers Island. Shortly thereafter, the Administration for Children's Services ("ACS") intervened, and her children were removed from her care and custody. Even though Ms. P. has since been released from detention, she is not only fighting a criminal case but also faces the additional enmeshed penalties of family separation in Bronx Family Court.

As these lived experiences of our clients demonstrate, we need to recognize the critical dangers of forced institutionalization, which mimic the deleterious harms of carceral punishment when law enforcement is given increased power and authority to make clinical diagnoses and presume an individual's threats to public safety in the absence of medical recommendations. Additionally, we believe that police officers resorting to the use of excessive force when executing an involuntary removal raises a host of concerns along constitutional and civil rights grounds, and we condemn such a directive for creating a basis to escalate rather than to de-escalate conflict.

II. Rather than supporting the goals and protocols that underlie the Mayor's Directive, the City must instead invest in resources such as emergency housing and community mental health to ensure that vulnerable New Yorkers suffering with mental health challenges have access to essential support services.

We believe that investment in community resources to keep New Yorkers with mental health challenges safer demands a commitment to compassionate mental health care. It demands a commitment to ensuring that transitional and supportive housing are treated as pathways for stability. As such, The Bronx Defenders urges the Council to rescind the Mayor's Directive and instead invest in community mental health services and housing, investments that directly respond to the needs of this vulnerable group and offer voluntary support without entangling people in more harmful systems.

As an extension of this overarching policy recommendation, we ask the Council to permanently fund the Mayor's Office of Criminal Justice ("MOCJ") Emergency Reentry Hotels, emergency housing that provides barrier-free, holistic social and support services, including humane medical care, and offer residents access to vocational and educational opportunities and pathways to permanent housing. The emergency reentry housing previously run by Exodus Transitional Community and now overseen by Housing Works, along with the medical and mental health services provided on-site by Housing Works, have been life-changing for so many of the people we represent. This safe, stable, and immediate housing avenue addressed an unmet need that had persisted long before the pandemic began.

The current need for safe, reliable, transitional housing is all the greater given how jail populations have risen to pre-pandemic levels, and how carceral facilities are overcrowded and deadly. This is a resource that not only decarcerates by providing immediate access to housing, but also provides people struggling with mental health and substance use with wraparound, onsite support. We hope to achieve a commitment to fully fund—and baseline in the City budget—the over 800 emergency reentry housing beds and wraparound reentry support for New Yorkers being released from city and state custody. We also hope to be able to address the stagnant wait list for this crucial service and collaborate to find a way to receive the 400+ people currently waiting for a bed, many of whom are currently at risk of imminent harm on Rikers.

Additionally, we know that currently, waiting lists for community mental health services are extremely long, especially for those who need to access a psychiatrist to prescribe medications. Access to these services is even more limited for those with language barriers or who are unable to access health insurance. Waiting lists are also close to a year for Assertive Community Treatment ("ACT") and Forensic ACT team placement, arguably the most intensive community mental healthcare option currently available. Before hospitalizing people against their will, the

first response must be to fully fund and expand access to community mental health support that people can access voluntarily. In rescinding the policy and investing in community-based healthcare and long-term, supportive housing, the City would be diverting its resources away from policing and incarceration and towards more effective, rehabilitative solutions that would in fact strengthen public safety.

Thank you again for the opportunity to submit these comments and for listening to our oral remarks. We hope that our perspectives and policy recommendations are instructive to the Council, and we are happy to provide additional guidance upon request.

My name is Alex Graff, I'm a 4th year medical student on a path towards Emergency medicine, a neighbor, friend, peer-counselor, and community member and I am alarmed and outraged by Mayor Eric Adams' directive to forcibly relocate people experiencing homelessness under the pretense of providing mental health care, and his proposed legislative agenda that would expand criteria for involuntary psychiatric admission. By employing an interpretation of the Mental Hygiene Law that allows police and frontline workers to detain "persons who appear to be mentally ill and who display an inability to meet basic living needs," and proposing to apply those same criteria to involuntary hospitalization, the Mayor's plan criminalizes people experiencing serious mental illness or poverty and violates civil liberties, without increasing mental health care access.

Mental health care is indeed inaccessible in NYC. Individuals experiencing severe mental illness face numerous systemic barriers to care, including: a paucity of non-carceral providers, financial barriers to outpatient care, limited peer-led community resources, and closures of psychiatric hospital beds. **I have seen this firsthand both as a medical student spending hours on the phone calling providers attempting to get my patients access to care with no success, and as a friend trying to help my friends navigate the mental healthcare system.** Involuntary transportation to emergency departments (ED) for evaluation does not address the sources of these barriers to mental health care. Coercive care is ineffective, fragmented and increases risk of harm and trauma**. I've seen the consequences of overwhelmed Emergency Departments: patients waiting for days in chaotic, traumatic environments, staff climbing over stretchers to care for their patients, nurses overwhelmed by impossible patient loads.** The Mayor's plan misdirects resources and will further overwhelm EDs, Comprehensive Psychiatric Emergency Programs and scarce inpatient psychiatric beds, rather than increase access to desperately needed resources and care.

Further, the Mayor's plan increases the risk of harmful criminalization and stigma, particularly for Black and Latinx New Yorkers. It is well documented that Black and Latinx people are disproportionately likely to experience homelessness in NYC due to structural racism in housing, healthcare, policing, and other systems. As such, the vague criteria "[ability to meet] basic survival needs," and "ability to adhere to essential outpatient treatment" target those already facing structural barriers to basic services and care, namely disabled, non-white, poor and working class, and LGBTQ+ people. Plainly, this policy only further entrenches white supremacy, structural racism, and carceral ableism. As an NYC healthcare worker who recognizes racism as a public health crisis, I refuse to be complicit in such a proposal.

Finally, the solution to an inability to meet "basic needs" is robust resources to meet those needs, such as permanent supportive housing, financial support, and universal mental health, substance use and medical care. Comprehensive mental health care must include a continuum of services from low intensity outpatient visits to frequent, high intensity individualized care, to a trauma-informed crisis response and recovery support system that includes peer support and peer respite, crisis prevention, de-escalation, and emergency care. Furthermore, the definitive solution to homelessness is safe, permanently affordable housing. We need legislative infrastructure for health care and housing systems that are made for people, not profit, including:

- The New York Health Act
- Good Cause Eviction Protections
- Housing Access Voucher Program
- Tenant Opportunity to Purchase Act
- Rent Guidelines Board and Emergency Tenant Protections Act reforms
- Social Housing Development Authority
- Fair Chance for Housing (Int. 632)

At its core, this directive criminalizes poverty and homelessness and weaponizes psychiatric hospitalization. We must respond to mental illness and homelessness with access to safe, affordable, permanent housing, financial support, community care, and universal comprehensive health care, *not* forced psychiatric hospitalization.

Good ~~morning~~ afternoon, ladies and gentlemen of the Council:

My name is Karim Walker and I am an Outreach Worker and Organizer at the Safety Net Project.

Compassion and dignity, that's what I want to talk about today. Because they are central to why we are here today. City Hall's call to hospitalize homeless people involuntarily (and allow police officers to use their discretion) should give this body and the city pause in how we treat the most vulnerable and dispossessed in our city.

While Mayor Adams has billed this as a mental health directive, it is clear who the intended targets are: the city's street homeless. Over the past year, the mayor has shown a willingness to use as aggressive a tactic as he can to criminalize homelessness in New York. He has shown that willingness to be a bully when it comes to homeless people as the street sweeps have indicated, across all parts of the City every day and last week at the Watson Hotel. And these forced hospitalizations will be no different from sweeps and another part of his plans to police our homeless neighbors out of sight without properly addressing their material needs.

My office has worked with homeless individuals who have been threatened with hospitalizations, such as a military veteran sleeping at Washington Square Park who was forcibly removed and hospitalized by outreach who'd refused to believe that he was an accomplished trumpeter as well (or that he was a military veteran). We also worked with men at Manhattan and Brooklyn who have been threatened with hospitalizations during sweeps as a means of harassment.

The forced hospitalization of homeless people (who may not necessarily have a mental illness) and by police officers who do not have the medical or psychiatric training to recognize a mentally healthy person from someone who is not could have disastrous consequences for the city and the individuals in question.

We also have misgivings regarding the demographics of those who this directive will impact the most. As we know, Black and Latinx make up the overwhelming majority of the homeless people in New York, and two groups that throughout this city's history make up the disproportionate majority of interactions with the police (interactions that repeatedly have ended in violence or worse). This measure fails to guarantee that the homeless will have the dignity and respect that they deserve and their encounters with the police will be safe and uneventful.

My concerns about who this directive will target the most heavily also reflect my concerns about transparency regarding it. Not much regarding how many homeless New Yorkers detained under these conditions, nor the institutions themselves participating in this directive has been released. If Mayor Adams believes he is acting in good faith, then why hasn't he come forward with details regarding this directive?

This directive is also a costly direct assault on the NYC Human Rights Law (among other statutes, such as the Fourth and Fourteenth Amendments of the US Constitution and the Americans with Disabilities Act) as has been argued in ongoing litigation. Our municipal budget is a moral document, reflecting the concerns and priorities of our elected officials. By increasing the budget for the NYPD while simultaneously slashing funding for public and social services, Mayor Adams has shown his cards and where his loyalties lie.

There is no dignity in the Mayor's plan, nor is there a modicum of compassion. The only way a homeless person can get those is through stable housing, which is the only legitimate way to end homelessness. This city can and must do better when it comes to homeless residents. And it starts by treating housing as a human right and necessity, and not as a luxury that only some get access to. Thank you.

2/6/23
Nadia Swanson, LCSW
The Ali Forney Center
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Testimony: Mayor's Initiative on Involuntary Hospitalizations

Hello,
Thank you to the committees for hearing our testimony today. My name is Nadia Swanson,I am a licensed clinical social worker with 12 years in the field, and the Director of Technical Assistance and Advocacy at The Ali Forney Center. AFC is the largest and most comprehensive service for LGBTQ+ youth experiencing homelessness. Over 2000 youth a year access our 24/7 drop in, clinical services and housing programs. And we oppose this initiative.

We are all in agreement that we want all new yorkers to be able to get the care they need; but this initiative is not the way to do it, it is harmful, criminalizing, stigmatizing. Having police be the first response to mental health needs shows a complete lack of understanding of the issue. For youth, just the presence of police will enact their fight or flight response creating the self fulfilling prophecy the cops will need to in order to justify their choices.

Someone with mental health needs…. someone in psychiatric crisis …and someone who is enacting violence are not the same thing and when each is handled correctly it is done with thoughtfulness,equitably, honoring their worth and self determination. This initiative conflicts with our professional values and code of ethics that we are licensed to uphold. We go through years of specialized education, internships, exams, supervision, and ongoing work to confront bias in order to be able to assess the nuance of imminent risk and when other services for safety can be provided.

NYPD can’t do that in a few hours of training, especially with the values of the NYPD. We have seen too many times that people be killed during a mental health call. This is especially true for LGBTQ youth, who are disproportionately black, brown and trans. And it does not address the specific needs of LGBTQ youth. Because of this we do everything we can to avoid police interactions with our youth.

Others have shared the history of violence and trauma youth cope with from police interactions and lack of hospital resources So I will share a quick story:

One day at our drop in center I responded to a youth that was screaming in the hallway about wanting a gun to shoot themselves. Over the course of the next hour I sat on the floor with her,listened, built rapport, was able to keep them with me instead of her running away using my clinical skills, give tangible resources, art materials to express themselves, allowing them space to be in privacy without the pressure to speak. By the end she was calm and I was able to determine that she was not actually thinking of harming herself and was reacting to how the NYC system had failed her. We were able to end with a safety plan, find them an emergency shelter bed and outpatient services. I see my coworkers do this every day. If she had been confronted by police at that moment it would have ended in physical violence against her. You can't learn that in an hour of training.

This initiative is a waste of time and resources, especially when we all know the answer : housing and early intervention for degenerative SMI; no barrier, affirming mental health care; peer to peer support, expanding programs like B-Heard (which was very successful for our drop in center), RHY mental health shelters and housing, housing, housing.
Thank you

Public Safety Hearing Testimony re: Oversight on Mental Health Involuntary Removals & Mayor Adams' Recently Announced Directive

Rabbi Joshua Stanton, Feb 6th, 2023

Good morning, Chair Hanks, Chair Lee, Chair Narcisse, Chair Ariola, and Council Members.

I am Rabbi Joshua Stanton, speaking on behalf of Tirdof: New York Jewish Clergy for Justice, a joint program of T'ruah: The Rabbinic Call for Human Rights and Jews For Racial & Economic Justice (JFREJ), the latter of which is a member of Communities United for Police Reform. I am testifying today to express my deep concern about Mayor Adams' involuntary removal directive.

Throughout the centuries, Jewish tradition has both acknowledged mental health as a human need, and urged us to assist those struggling to find treatment and solace, not in isolation but within a communal context. Removing individuals in psychiatric distress who are not a danger to themselves or others from their neighborhoods or public spaces further isolates and stigmatizes these New Yorkers. It denies them the community contact necessary for each person to thrive.

I agree with Mayor Adams that we must find solutions to the crisis facing unhoused New Yorkers suffering from mental illness. But instead of investing in genuine care and compassion, the Mayor's directive proposes additional police encounters, which hold the potential to become violent. Given the NYPD significantly more scope and authority to detain people is playing fast and loose with the legal rights of New Yorkers – especially given the NYPD's troubling track record with individuals experiencing, or perceived to be experiencing, a mental health crisis.

Jewish tradition urges us to care for our neighbors, especially when they are in trouble – and irrespective of cost. We learn from the 16th Century legal text, the *Shulchan Aruch* [Kitzur Shulchan Aruch Siman 184:8], "If you see that your neighbor is in trouble, and you are able to save him, or to hire others to save him, you are obliged to trouble yourself or to hire others to save him…. You may not shirk your duty because of this, and you must save her at your own expense [if she is not able to pay]. If you refuse to do so, you are guilty of transgressing the negative command, "Do not stand idly by while your neighbor's blood is shed..."

I know the members of this committee and of the entire city council do not want to be the people who stand idly by while our neighbor's blood is shed, or our neighbor is in deep distress.

I urge the council to reject the Mayor's directive and instead invest in genuine care and compassion, which means housing, mental health services, and social supports. Unless the City of New York adequately invests in the long-term health and well-being of New Yorkers and affordable housing, our mental health crisis will continue.

Hello, my name is Dr. Ashley Brittain and I'm a resident physician in Emergency Medicine in the Bronx and a regional delegate for the Committee of Interns and Residents.

I'm here on behalf of myself and my union to express, as so many others have done, a deep opposition to this violent directive.

I'm also here to explain what happens at the other end of this process, in the hospital. I have to warn you that what I am about to share is intense.

When someone is involuntarily brought into the hospital by police, after suffering that immense trauma, they will then be placed in a yellow gown to indicate that they are an "elopement risk," meaning, there is a concern that they will leave.

They'll be told that we need their blood and urine to test before we send them to our main emergency department or psychiatric ED, and if they don't cooperate, they'll be restrained, either chemically, or in extreme cases, they'll be physically strapped to a gurney. They may wait in a crowded emergency department for days for a psychiatric bed to open up.

It is beyond evident that this is not the health care we have dedicated our lives as physicians to provide. There is no other way to describe this process than as an extension of the carceral system, one that will contribute to the ongoing problem of folks cycling in and out of our hospitals without ever receiving proper long-term mental health care in the community.

I also believe that one of the most important responsibilities I have as a physician is to uplift and safeguard my patients' autonomy–their ability to make decisions about their own health and life. This is a human right, and this Adams' directive seems to operate under the principle that if someone is homeless, they forfeit that right.

Well I refuse to accept that. And our City Council should refuse to accept that.

Instead, our elected officials here today should join me in demanding the mayor revoke this directive immediately, as an urgent matter of racial, economic and disability justice, and of public health.

Oversight – Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan

T2023-2843

Monday, February 6, 2023

First Do No Harm

↔

Good Day, Mental Health, Disabilities and Addiction Committee Chair and Members.

Today, I am requesting that the Mayor's Mental Health Plan be re-evaluated as it relates to the use of police to involuntarily remove people they deem to have mental health conditions into hospitals, without the individuals even being a danger to themselves or others. I also want to ensure that the City does not merely substitute mental health professionals for police, as some mental health professionals are harming our neighbors who need care and placing them in dire circumstances. The solution instead is to center Peer Specialists (individuals with lived mental health experience who have received extensive training in health and mental health care) in a fully transformed mental health crisis response.

Before I continue, I would like to introduce myself. My name is Christina Sparrock. I am a certified public accountant who lives with a mental health condition. I am also a staunch mental health advocate and the founder of the Person-Centered Intervention Training Mental Health Response (PCIT), a program that destigmatizes mental health conditions. The PCIT program is a person-centered, strength-based, trauma-informed, and empowering model that "meets people where they are at" and removes the emphasis on "what's wrong" with a person, instead focusing on "what happened." For instance, a person may need immediate housing and, as a result, have an emotional break. Connecting the person to housing and offering them voluntary mental health services to deal with their emotional state is the needed response – NOT incarceration or hospitalization. Not only is PCIT effective for people living with mental health conditions, but it benefits others living with substance use/ misuse and those who are justice-involved or unhoused, and the general population overall. Whether it's a law enforcement officer, a teacher, a surgeon, or a psychiatrist, mental health conditions can affect everyone. It's not a "them" issue, it's a "we" issue! In addition, the PCIT program employs Peer Specialists, who are vital to the program's success, to help divert

people from law enforcement to treatment and services. Peer Specialists understand, have walked in the shoes of others in need, and know the path of recovery.

"A Mental Health Condition is not a crime"

It's about normalizing the condition, providing people with services based on their unmet needs, and having empathy and patience.

Sadly, our default system for mental health emergencies has always been to use public safety or law enforcement as first responders. And things have been hugely exacerbated under the Mayor's new policy, as law enforcement now has the authority to involuntarily remove people they deem to have mental health conditions into hospitals, without the individuals even being a danger to themselves or others. Notably, hospitals can be traumatizing and retraumatizing for many.

Although mental health professionals are a better option than law enforcement for engaging with people with mental health conditions, there are still red flags within the mental health system that must be addressed and rectified. According to a recent article in The Lancet Psychiatry, there is a growing body of evidence of mental-illness condition-related stigma in health care, including negative attitudes and stereotypes, prognostic negativity, diagnostic overshadowing, insufficient skills of health care providers, discriminatory behaviors, and perceptions of unfair treatment among consumers of mental health services[1]. Unfortunately, this translates to many mental health professionals who have taken the Hippocratic Oath to **First Do No Harm**, to in fact, do, and continue to do, harm. Without being treated with dignity and respect, and without having access to trauma-informed and person-centered care by peers, people with mental health conditions have decompensated, ended up hospitalized, jailed, unhoused, and unemployed, have fallen victim to crimes, and continue to be subject to a plethora of emotional, physical, and psychological attacks, due to no fault of their own.

For example, right in my backyard in District 35, people living with mental health conditions and substance use/misuse, and those who are unhoused and justice-involved, have fallen victim to a

[1] Knaak S, Patten S, Ungar T. Mental illness stigma as a quality of care problem. *The Lancet Psychiatry* 2015; 2: 863-64, http://www.thelancet.com/journals/lanpsy/issue/current.

community- based organization and mental health organizations, which unfortunately led to an UNwellness, rather than a wellness program. Due to their neglect and inattention:

1. People in need didn't receive treatment or a continuum of care
2. People of color received less care than their white counterparts
3. A person designated to have a continuum of care went missing
4. People overdosed
5. Peer Specialists-
    a. Reported a hostile work environment and were bullied
    b. Went on medical leave, were hospitalized, or quit
    c. Were threatened to be reported to human resources for any reason
    d. Were berated, insulted, humiliated, slandered and defamed
    e. Were denied access to treatment
    f. Were forced out of the public area and instructed never to return
6. Funders and community members were misinformed

I would like to share more details about the specific problems I encountered and ask that the City Council investigate the abuses I have noted.

Many vulnerable people fear consequences and are forced to be silent, while many of these city, state, and foundation-funded agencies go unpoliced and unpunished. Needless to say, and for the reasons set forth above, this is why innocent people fall victim to our systems and end up unwell and unhoused and then, under the Mayor's plan, are involuntarily removed by police. The Mayor must promote prevention and intervention wellness models rather than criminalize and force-hospitalize people. We must stop a crisis before it happens, which means having peers actively engage with people the right way and right away.

As a solution, I have three requests of the City Council: first to support and fund Peer-Run response pilots like PCIT; second, to mandate culturally responsive, trauma-informed and person-centered training designed by Peer Specialists for all health professionals – and especially mental health professionals – and last but not least, to create an <u>Independent Peer Advisory Council</u> that has the

authority to access data on the quality of services of all health professionals, advise on best practices, assist in introducing and reviewing legislation, and issue public reports.

Thank you for your time.

Christina Sparrock
christina.advocacy@gmail.com

My name is Dr. Jackson, I'm a psychiatrist and chief resident at a large medical center here in NYC. Today I'm representing a physician advocacy group called the New York Doctors Coalition. My uncle who has schizophrenia and experienced homelessness for many years was shot by police while experiencing a mental health crisis. I know the pain and fear this brings to families of loved ones with serious mental illness. I hear that fear every week in my work as a psychiatrist, when speaking to my patients and their families who are afraid to call police in times of crisis, knowing how deadly that "call for help" can be.

Those experiencing homelessness with mental illness do need our help, but forcibly removing people from our streets and dropping them off at emergency departments is not the solution. If the mayor truly wants to help our brothers and sisters, aunts and uncles who are living on the streets, then we must invest in evidenced based solutions with a top priority being a massive increase in permanent supportive housing. The numbers are clear, every time New York has taken a housing first approach and invested in permanent supportive housing, homelessness has dropped. Furthermore we need to invest in non police mental health crisis first responders as well as voluntary, community based treatment interventions which have been proven to be more effective than the involuntary solutions that they proposed.

As a doctor and nephew of someone with serious mental illness, I know how important it is to get his right, and the deadly consequences if we get this wrong. Thank you.

Testimony
New York City Council Committee on Mental Health, Disabilities, and Addiction
(Jointly with the Committee on Hospitals, the Committee on Fire and Emergency Management, and the Committee on Public Safety)
February 6, 2023

Eric Vassell
Father of Saheed Vassell
Justice Committee Member

My name is Eric Vassell. I am the father of Saheed Vassell, who was killed by the NYPD on April 4, 2018. I am also a member of the Justice Committee, an organization that works with families who've lost loved ones to the police.

I am here today to oppose Mayor Adams' directive to force hospitalization on people with mental illnesses. This is not a plan. It is just giving the NYPD even more power to sweep people off the street just because officers think they don't have a place to stay or have a mental illness.

This is the opposite of what our communities need. We need affordable housing and quality mental healthcare. I know this firsthand because I watched the City's healthcare system fail my son long before the NYPD killed him.

Saheed first started to struggle with mental illness after his close friend was killed by the police. He needed help to process this trauma. As much as my family tried, we could not find any programs in our community that would actually help him and treat him like a human.

Without anywhere else to turn, we would call 911. The police and EMS would take him to the hospital but instead of helping, they just gave him a whole lot of pills to take. They just wanted to lock him down somewhere, instead of giving him proper care.

For Saheed – being in the hospital was like being in prison. It traumatized him more and made his condition worse. The medication just slowed him down.

What my son needed was quality long-term mental healthcare with professionals capable of treating Saheed as a human being. Instead, he was criminalized and dehumanized.

Over four years ago, NYPD Anti-Crime and SRG officers murdered my son at a busy intersection in broad daylight. They jumped out of their vehicles and immediately began shooting with no warning. My son was unarmed. He was never a threat to the NYPD or civilians. None of the officers who murdered my son were ever held accountable.

My son is not the only person that the New York City healthcare system failed and allowed to be murdered by the NYPD. Mohamed Bah's mother was not able to find services to get her son help, so she called 911. The NYPD showed up and killed him. Kawaski Trawick lived in a facility where he was supposed to receive care, but instead, its staff called the police on him and the NYPD murdered him in his own home.

What happened to my son and too many New Yorkers proves that our healthcare system is broken and the NYPD should not be used for mental health response.

Too many community members do not have homes. Too many people struggle with mental illness. Some people turn to drugs or alcohol. With the pandemic, it has only gotten worse. People are on the streets because they don't have anywhere to go. They don't have jobs. They don't have services they need.

But instead of making a plan to address this, Mayor Adams is actually cutting budgets for housing and mental healthcare and he is throwing more police at this problem. Police officers are not health professionals. They do not have the skills to diagnose people or provide care for them. They only have the skills to criminalize and arrest people.

We cannot allow Mayor Adams forced hospitalization directive to continue. I am calling on the New York City Council to stop the mayor's directive and to invest in housing, community-based mental healthcare and other services for our communities.

As long as the NYPD continues to be involved in mental health response and addressing homelessness, there will be more Saheed Vassells, more Mohamed Bahs, and more Kawaski Trawicks.

Testimony of Dr. Kate Sugarman, Physician in Community Care Clinic and Steering Committee Member of NYLPI's Medical Provider Network

To the Committees on Hospitals, Jointly with the Committee on Mental Health, Disabilities and Addiction, the Committee on Fire and Emergency Management and the Committee on Public Safety

Regarding Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan

My name is Dr. Kate Sugarman, and I am a family medicine doctor in Washington D.C. that has been practicing in community health clinics since 1991. My medical training and practice include diagnosing and treating psychological conditions such as depression, anxiety and Post Traumatic Stress Disorder. I also volunteer with New York Lawyers for the Public Interest's Medical Providers Network as both a medical provider and Steering Committee member. This network advocates on behalf of immigrants in detention who have serious medical conditions, as well as supporting the release of those with unmet medical needs. These clients include residents of New York. Even though I am a physician outside of New York City, I am concerned by the broader implications of supporting a carceral system instead of actual systems of care.

I was outraged to learn of Mayor Adams' directive of involuntary detainment as a mental health crisis response. Involuntary detainment is not a treatment option. It only further drives the criminalization of mental illness. Many of my patients face challenges with mental health and housing and food insecurity. A proposal that further enables police violence against them is not the answer. I fear that this directive will continue to normalize the criminalization of mental health instead of addressing the barriers to accessing care.

Forcing individuals into psychiatric care is not a plan for care. Involuntary detainment often leaves them worse off, and fails to give them the care they actually need. The emergency rooms that these individuals are sent to have long waits, there is a shortage of psychiatric hospital beds, and people brought in for involuntary psych evaluations are frequently released without any treatment or services they need upon discharge. New York City's hospitals do not have the capacity to effectively care for those subjected to the mayor's involuntary removal policy. Not only that, but involuntary removal is essentially incorporating hospitals into the carceral system. Doctors, nurses, and hospital staff will be forced to become an extension of that system, and forced to be part of the retraumatization of those individuals seeking help.

Despite evidence that police as first responders lead to repeated violent encounters, they continue to be the *de facto* first responders to mental health crises in New York City. Calls for assistance with mental health crises are routed to police, but police often escalate the mental health crisis, and frequently physically injure people involuntarily brought to the hospital for psych evaluation. This leads to fear and mistrust of the city's police-led response system. It deters people from seeking help or care, even during a mental health crisis. Police simply are ill-equipped to de-escalate and safely address mental health crises. They do not effectively connect people to care or mental health services. Our bloated criminal punishment system reflects a historical and continuing lack of investment in the health and well-being of people and communities. Detaining individuals in psychiatric hospitals is not the answer to unaddressed mental health needs that drive far too many interactions with law enforcement.

We need to turn away from police-based systems. The only appropriate response for a mental health crisis is a healthcare response. People should be diverted to treatment as early as possible instead of being subjected to law enforcement response or penalties. We need to create safe spaces that empower and uplift people instead of criminalizing them. These crisis calls are the result of the lack of community-based treatment and the shortage of psychiatric care. There are people living in the streets who want voluntary medical care but are not receiving it. A true care plan would address these barriers to access, and would also focus on community based support ensuring that individuals have food, housing, and services to voluntary medical and mental care.

A mental health crises response system should remove police and emphasize reducing trauma and violence, promote connections to mental health support services, and reduce the burden on psychiatric facilities. This is the right time for the City to make a parallel investment in resources that can meet the needs of people with serious and persistent mental illness and behavioral health needs, in ways that will prevent contact (or further contact) with law enforcement at each possible juncture. It is fully within this city's capacity to provide robust care in communities to prevent mental health crises and interaction with law enforcement by expanding supportive housing, expanding site-based treatment, expand field-based treatment.

We thank members of the City Council for their continued support. It is essential that New York provides people with appropriate services that will de-escalate mental health crises, and that ensure their wellbeing and agency. We hope that the City Council will hear the concerns raised, and will support community-based alternatives instead of police-based systems. Thank you for this opportunity to address involuntary removals, and to speak on what a true healthcare response to mental health should look like.

Dr. Kate Sugarman
Primary Care Physician
Steering Committee of NYLPI's Medical Provider's Network
151 West 30th Street, 11th floor
New York, NY 10001
(301) 343-5724

Since 1976 New York Lawyers for the Public Interest (NYLPI) has been a leading civil rights and legal services advocate for New Yorkers opposing marginalization on the basis of race, poverty, disability, and immigration status. Our community-driven work integrates the power of individual legal services, impact litigation, and comprehensive organizing and policy campaigns. Guided by the priorities of our communities, we strive to create equal access to health care, achieve equality of opportunity and self-determination for people with disabilities, ensure immigrant opportunity, strengthen local nonprofits, and secure environmental justice for low-income communities of color. NYLPI's Health Justice Program brings a racial justice and immigrant rights focus to health care advocacy in New York City and State. NYPI's Health Justice Program has documented conditions in immigration detention and assisted seriously ill immigrants in obtaining necessary medical care. With the help of doctors in NYLPI's Medical Provider Network, we connect numerous detained people with medical providers to advocate on their behalf.

New York City Council

Oversight Hearing with Committee on Mental Health, Disabilities, and Addiction, Committee on Hospitals, Committee on Fire and Emergency Management, and Committee on Public Safety

February 6, 2023 at 10:00am

Testimony by: Kate Whittemore, MPH

Re: Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan

Good morning Chair and City Councilmembers. Thank you for holding this oversight hearing today to hear from community stakeholders and people with lived experience.

My name is Kate Whittemore, and I am testifying today as an Advocacy Ambassador with the National Alliance on Mental Illness of New York City. As a public health professional and a person living with schizophrenia, I feel strongly that the city should oppose the Mayor's plan and that there are better alternatives to support New Yorkers with serious mental illness.

I began hearing voices in early 2018. At the time of my mental health crisis, I was extremely fortunate to have permanent housing, health insurance, and a strong support system. After a brief hospitalization, I started a medication that allowed me to get back to my normal life. Today, I live independently and have a full-time job at Weill Cornell Medicine.

Not everyone living with a serious mental illness is as privileged as I was. For those without permanent housing and health insurance, it can be nearly impossible to find the right healthcare and medication. I am grateful that New York City is finally paying attention to a vulnerable population that is too often forgotten.

However, the Mayor's new plan to use NYPD for involuntary hospitalization is more likely to threaten than improve the health of New Yorkers with serious mental illness. NYPD officers are not medical professionals and are not trained to recognize psychosis. Encounters between police and people with serious mental illness may have horrific consequences, particularly for Black New Yorkers and other New Yorkers of color.

Even if more potentially lethal interactions with the police can somehow be avoided, the Mayor's new strategy is a Band-Aid at best and an affront to human dignity at its worst. Getting started and then staying on treatment is difficult enough for people like me who have permanent housing and health insurance, let alone those who do not.

For these reasons, I ask this Committee to seriously consider opposing the Mayor's plan on involuntary hospitalization. Instead, I ask the Committee to support evidence-based policies including passing the New York Health Act, providing free permanent supportive housing to any New Yorker with serious mental illness, and allocating additional funding to expand mental health clubhouses.

Thank you for your time.

To: New York City Council

From: Marion Hoffman Koenig, NYC Resident, and Mental Health Advocate

Re: Hearing on Mayor Adam's Involuntary Removal and Hospitalization

Date: February 6, 2023

1. As a long-term New York City resident, I fully support NAMI NYC's proposal to work with City Hall to create a more comprehensive and humane approach to the care for those with Serious Mental Illness (SMI).
2. I further support NAMI-NYC being the initial say in a Mayor's Advisory Board for those with Serious Mental Illness (SMI).

The City has also chosen to invest in increased police presence despite the deaths and harm during mental health emergencies. However, as a peer-led, peer-run organization, we know that peer-led non-police responses to a mental health crisis, such as the CCIT-NYC model, can be effective.

3. I refer Mayor Adam to the following article in The New Yorker: Sending *Help Instead of the Police in Albuquerque*

A novel community-safety department has been taking calls off the hands of a force with the country's second-highest fatal-shooting rate. Has it improved public safety? By Murat Oztaskin, February 4, 2023

4. The City has the power to provide onsite treatment and treatment in homeless shelters or supported housing but has chosen not to.

Hello, my name is Dr. Michael Zingman and I'm a resident physician in psychiatry at Bellevue Hospital and Secretary-Treasurer of my union, the Committee of Interns and Residents, which represents more than 6500 physicians in New York City.

When Mayor Adams first announced the Mental Health Involuntary Removals Directive, my fellow CIR members and I were outraged.

We found it appalling that, as patients face long wait times in our overcrowded hospitals, as people are evicted because they can't make ever increasing rent, as our neighbors face the constant threat of incarceration and deportation, our Mayor would focus his attention on increasing police power to further criminalize and involuntarily hospitalize houseless individuals.

We understood that this directive may result in critical danger for the people it impacts, particularly if they are Black, undocumented, disabled, or LBTQ.

As a psychiatrist who took an oath to do no harm, I cannot stand by as houseless New Yorkers are further criminalized and endangered by police, and then forced into a hospital stay that by its very nature cannot address their needs.

Let me be clear: When someone is brought into the hospital by the cops, no matter how hard we as staff work to provide quality care, we cannot change the violent way that patient arrived, and we cannot provide true care. True care requires patient trust and safety–which this directive casts aside with abandon.

Rather, the Adams' directive will make physicians and other healthcare workers an extension of the carceral system–it will force us to compound the trauma of folks already experiencing the daily trauma of houselessness by keeping them in the hospital against their will.

This will also erode patients' trust in their physicians and the healthcare system, which is so key to providing quality care and improving mental health outcomes.

As so many people today have stated, there are real needs in our community that Mayor Adams and this Council must address. We need access to affordable housing, clean air and healthy food, we need jobs that pay us fairly, we need long-term, community-based mental health care.

Specifically, in terms of mental health support, funding non-police mobile-response units like B-HEARD would be a great place to start. We also need more transitional housing units, respite beds, and extended care units, which are inpatient psychiatric units like those at Bellevue, where individuals stay longer and get linked to housing and ongoing care.

There should be an easier process for more rapidly building supportive housing and an increase in assertive community treatment (ACT) teams that deliver care in the community. Crucially, H+H needs more funding to help with staffing in general, so we can better serve our current patients and in order to support any increase in psychiatric beds.

These are the sort of measures that I know as a physician would most positively impact my patients' health.

These are the directives I wish we could discuss.

2/6/2023

Dear NYC Councilmembers,

My name is Sam Kokoska and I am a medical student who is receiving medical training a NYC medical school. I am also a member of NY Docs, a coalition of NYC healthcare workers committed to universal, equitable, accessible quality healthcare for all. I also directly care for folks experiencing mental illness, mental health conditions, mental health distress (acute and chronic), acute crises, and expressed suicidality (acute and chronic), through the hospitals and clinics in which I work.

Along with 130+ healthcare workers who signed our letter expressing alarm and outrage in response to the Mayor's involuntary removal directive. I have been listening to today's NYC Council hearing regarding the directive and feel persistent outrage. As we express in our letter, this policy completely fails to address systemic barriers to mental health care and will overwhelm an already burdened health care system. Not only does this policy completely fail to provide solutions for unmet mental health care and housing needs, but it also criminalizes, harms, and traumatizes homeless individuals and further entrenches structural racism and ableism.

The Mayor's plan increases the risk of harmful criminalization and stigma, particularly for Black and Latinx New Yorkers. It is well documented that Black and Latinx people are disproportionately likely to experience homelessness in NYC due to structural racism in housing, healthcare, policing, and other systems. As such, the vague criteria "[ability to meet] basic survival needs," and "ability to adhere to essential outpatient treatment" target those already facing structural barriers to basic services and care, namely disabled, non-white, poor and working class, and LGBTQ+ people. Plainly, this policy only further entrenches white supremacy, structural racism, and carceral ableism. I, along with 130+ NYC healthcare workers, refuse to be complicit in such a proposal.

I ask, how many individuals who created this directive have experienced involuntary hospitalization and/or acute mental health crises? How many of them have lived experience of homelessness? How many of them have spoken with folks and organizations led by individuals with lived experience of mental health crisis, disability, and histories of "serious mental illness"? I have listened to and worked with people experiencing acute and chronic mental health concerns, including severe depression, suicidality, and neurodivergent states. Individuals

with those concerns should be able to decide how and when to seek hospitalization, if/when to involve police, and what forms of care will best fulfill their needs.

As healthcare workers, we are here to listen to our patients and their lived experience. We are here to advocate for resources that best meet people's needs. The solution to an inability to meet "basic needs" is robust resources to meet those needs, such as permanent supportive housing, financial support, and universal mental health, substance use and medical care. Comprehensive mental health care must include a continuum of services from low intensity outpatient visits to frequent, high intensity individualized care, to a trauma-informed crisis response and recovery support system that includes peer support and peer respite, crisis prevention, de-escalation, and emergency care.

At its core, this directive criminalizes poverty and homelessness and weaponizes psychiatric hospitalization. We must respond to mental illness and homelessness with access to safe, affordable, permanent housing, financial support, community care, and universal comprehensive health care, *not* forced psychiatric hospitalization.

Sincerely,
Sam Kokoska

NYC Medical Student, NY Docs organizer, Q Clinic provider

The sudden focus on unhoused individuals who suffer from mental illnesses seems to me a media-driven scapegoating of Individuals with severe mental health problems. The problem is dreadful but the fact is that reduction in long- and short-term in-patient and outpatient care has been a point of shame last month…last year…the last decade…and for the last 40 years and even long before that. The city and state created the problem when it reduced funding/slots for treatment. Many more violent incidents by people who have homes and do not have a mental health diagnosis occur daily but are not reported in the media let alone given headliner status. Media feeds a public hunger for shock with its stories about the unhoused (each of whom, by the way, has a completely different story and by far the greater part are non-violent) . . . public outcry frightens the public . . . and suddenly, people with mental health problems are demonized

Out-of-the-box suggestions:

A big media campaign featuring people who are in recovery from or leading normal lives, the need for treatment, places to get help.

Work with the State Medical Board re: lifting the ban on certifying doctors who have had a mental health experience. We need more doctors who are committed to working with people with serious mental illness. Personal experience helps inform practitioners and often drives commitment to helping people like themselves. Psychiatry is not a specialization of choice because income is limited to time. Of those who do choose psychiatry, few choose hospital work as a career: it doesn't pay well and is not satisfying since insurance limitations on length of stay prevent the provision of real treatment and a revolving door of patients who return multiple times without improvement; etc.

Create an I.D. card and require in- and outpatient facilities to give one to each patient they admit with a recommendation that each patient carry it with them. It could include information about a personal contact who can provide information about the individual, or the name of the treatment provider. Because the latter could be a HPPAA violation, the provider would be required to explain that carrying it and showing it to anyone is not a requirement but could assist them if say in the middle of the crisis they are unable to describe their situation, provide the name of a contact or have them directed to professionals familiar with their situation.

June Lazerus

Feb 9, 2022

Katrina Corbell

Re: Feb 6 Hearing

I was unable to be physically present for this testimony as I finally did something I rarely do: self-care. It involved a retreat-like environment I had not realized was out of state yet gratefully did not let that stop me when I realized that.

As a Peer, and hopefully by now you are familiar with this term, definition, the difference between peer and Peer, and starting to understand why relying on unpaid Peers isn't going to solve systemic issues unless we revisit Occupy Wall Street topics and perhaps abolish capitalism, or at least the corrupt sides of it where billionaires can receive tax benefits for committing fraud while a parent, a father, gets jail and thousands in fines and loses custody of kid(s) for merely trying to get the bread, peanut butter, jelly, and milk his family needed and the SNAP balance was less than $2 short. (My details may be vegetarian-biased as I think it was meat, not pb; but he also could have been jailed and kid(s) removed for not feeding them enough, so what choice did he have? While the politicians determining the amount of SNAP receive more *per plate* *per meal* than a single adult receives in an entire month for all, ALL meals.)

I know, "but that's a federal issue." I see it as a people issue. Food is a grounding source. Food is what we all need to survive. Where people who oft don't get along will if it means receiving an esp hot meal, coffee, even dessert! It's when the humanity of humans can start to shine through the darknesses many struggle with.

From accounts I have heard, many people who are involuntarily taken to an ER that is understaffed and often overfilled in fact simply offer an involuntary patient the food on hand such as a refrigerated turkey and cheese or pb and jelly sandwich, crackers, a soda and sign them out. There is no housing. There is a 6+ month waiting list for therapists accepting medicaid, yet many people might not see a need or simply not want to go to therapy. A client needs to be willing to work on themselves for therapy to genuinely have an impact. A positive one, healthy one at least. Otherwise layers and layers of resentment are building.

Years ago a group of us from an affinity of Occupy Wall Street known as Occupy Trinity were having a discussion on Psychology and Psychiatry. My background includes graduate work in depth psychology including a traineeship, so I had a bit of a different perspective than my friends. They had ones similar to many on the streets, that they/we are not listened to, that diagnoses are made before we are even talked to, that a less than 15 minute session is not enough time to "know" what drug to give and often there are reasons why someone not on medicine is not on medicine, esp when a mental health practitioner has not done a full medical background or taken the 3+ full sessions to get to know a client's background. Get to know the client. In the U.S. and esp NYC everyone is running like fish out of water instead of meeting the clients where they, we, are at.

Classism, racism, sexism and other -isms are also at hand. People closest to the cis-white-heteronormative male, even those not white or male yet still yearning to climb the top of the capitalist champagne glasses and wine flutes of the trickle down glass pyramid, will insist

everyone can get better or get out of their funk by getting back to work. My experience includes learning about systemic issues. Inherited trauma. These are the things at play that *some* employers are aware of and willing to work with, but not all. Even AmeriCorps does not. Even the NYC DOE does not. I am willing to bet if you listen to the stories of the people you will be surprised to hear what isms there are that led to why they, we, are on the streets. Or subway stations. Or subways. Or wherever else Eric Adams is trying to evict New Yorkers from that technically he is the mayor of just as much as he is the mayor of the billionaires with the NIMBY attitude.

More Peer Respite Centers are one possibility. (These are different than the ones Supportive Housing providers run internally to get out of paying for hotels when a neighbor floods their surrounding apartments, by the way.) Currently in NYC we tend to have a waiting list for the best, and salmonella when it comes to the "needs to be improved"--hopefully they've improved their kitchen by now. Why not more, yet more organic, healthy ones versus housing developers attempting to make a fast buck? Ones that are designed to enable stepping stones other than sending people back to the hell known as dormitory shelters where assaults, drugs, spoiled food, no food, junior high type curfews that even those of us doing church-based work cannot get case workers to grant work exemptions for (even though the HRA even acknowledges it as "work!"), having shelter staff open doors every 45 minutes throughout the night to make sure we aren't dead (please research why humans need to complete cycles of sleep and what happens when we don't…it's even a military tactic hence NYC is doing this to our homeless in the shelters, causing some to not want to stay in shelters ot simply not enabling them to remain in shelters, and then threatening to institutionalize them for seeking sleep elsewhere?), plus so many other reasons ranging from sexual violence to placed 20+ miles away from community with zero assistance promised; things that may seem trivial to people with resources but, and this is key, by entering shelter one also is stripped of their cash assistance. Maybe not all name this as a reason, but one can go from approx $92-183 a month to $45. In the old days HRA tried to strip people of their SNAP, too, and luckily that was overturned. Don't even get me started with the histories of food quality in shelters, but a tl;dr is it used to be worse than prison food. Punished for being poor or/and less healthy or/and less fortunate. People have shared jail was better than the shelter, hence why many prefer the streets.

The process of being forced to not be in or on the streets can cause layers of new traumas, too. Re-triggering old things as well as brand new issues on top of whatever was lingering. How NYPD has treated them is another topic. What has happened to more social workers with supplies on the streets, and invitations (ie choices, offerings) to either the workforce type shelters via private parties not wishing to wait for DHS so handshook a deal with the mayor (at least at the press conference), or the MTA shelter proposed under DeBlasio than postponed due to COVID-19 and now Adams had rubber stamped his name to it? Those were not going to be by force, rather by choice. Made possible to allow a person to choose to go there, to accept the offering as a stepping stone to more permanent housing, placement.

I know a few people who are not on the streets because they do sleep under their desk at work. Buildings have a gym so they'll go shower and make it seem like they are early. When work ends go out for dinner or drinks, so on. Go back to "work late" and then find a way to grab sleep. It's been depicted in movies and tv shows, I'm sure, but it's how some New Yorkers New York in Hell's Kitchen a Studio or 1 Bedroom is going for around $6000. What job pays $18000 a month to qualify for rent?! Let alone the amenities for access to the rooftop or basement luxuries. Hence why sidewalks and subways are less expensive and more reasonable. But they are not at risk of being involuntary institutionalized because they are clever? Talk to a psychiatrist with a

handy dandy DSM V and they'll have some labels to throw at them. One of my professors notes over 98% of all humans can find at least one DSM diagnosis applicable to our current state of being. It's like a "how to" guide for simply being human. Our society tends to just respect certain ones more than others and such selective biases is what I fight against.

Why not create more open, accessible, VOLUNTARY drop-in centers and WITH appropriately trained and paid staff, preventing high turnover so those on the street can begin to develop relationships beyond the soup kitchens and occasional 9-5 non-profits running? There used to be one in lower Manhattan I have heard amazing stories about, but a certain church chose to not renew its $! Per year lease to keep it running. That's an example of why we Occupy. ;) We need those up and running again. Peer based, peer run, peer led, peer supported. For the people (peers), by the people (peers) as we have been there, done that, get it. Aren't doing it for the camera, the publicity, the donors, the next political campaign, the resumes. We do it as Peers. Not paychecks, not profits. People over profits, still applicable, always applicable.

Back to the main point of voluntary versus involuntary, please, please look at the history and stories of the Peer Movement and the institutions of NY. What led to some, many being shut down and why even hospitals especially in Brooklyn and Queens keep having to close. Listen to the stories of Peers that were involuntarily committed and did survive, and the horrors they are able to share. Their perspectives are more valuable than any line-item dollar amount.

Thank you.

testimony@council.nyc.gov

To whom it may concern:

We are advocates at the Urban Justice Center's mental health project who exclusively work with homeless new yorker's living with mental health concerns. In our role, we have witnessed the impact mainstream behavioral health care has on the safety and recovery of our clients. Hospital settings are designed to treat patients from a myriad of backgrounds. As such, they are not necessarily best positioned to support the concerns of the type of clients AOT policy is attempting to address. More specifically, hospital staff are not always trained in trauma informed care of homeless individuals. In other words, they do not have expertise on the specific ways SMI presents in folks who have experienced/are experiencing homelessness. Homelessness is, in of itself, a trauma which is ongoing and best described by a diagnosis of complex PTSD which is consistent with symptoms of frequent mental health crises. By involuntarily hospitalizing those who appear to be having a mental health crisis this policy inherently targets and surveilles those who lack a private space to emote; Namely, those who are homeless. This policy strips individuals of their agency by legally preventing them from being the voice of authority on their own situation and, instead, forcibly placing them in an environment that only further exacerbates their symptoms. Upon discharge, clients return directly to homelessness only with more pervasive symptoms leading to an inevitable cycle of hospitalization/homelessness. Rather than subscribing individuals to an intervention that would bring them further harm, we ask that you pivot your approach to a more comprehensive solution that would allow clients in this situation to get the care that they need and live dignified lives. Specifically, please head NAMI's holistic approach which endorses the treatment not jail act and encourages further funding towards safe and affordable housing.

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: 2/6/23

(PLEASE PRINT)

Name: Cal Hedigan

Address:

I represent: Community Access

Address: 17 Battery Place NY 10004

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card T2023-284

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

☐ in favor ☑ in opposition

Date: feb 6th, 2023

(PLEASE PRINT)

Name: Alexandra Nyman

Address: 27 Margaretta Ct SI, NY 10314

I represent: Break Free Foundation

Address: 27 Margaretta Ct SI, NY 10314

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. T23-284 Res. No. _____

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: Helen Skipper (Skip)

Address: Bronx NY 62

I represent: NYC Justice Peer Initiative

Address: 151 Lawrence St 3rd fl Brooklyn NY 11201

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: 2/6/23

(PLEASE PRINT)

Name: Luke Sikirica

Address: _____

I represent: NY Association of Psychiatric Rehabilitation Servi

Address: 164 Washington Avenue

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: 2/6/23

(PLEASE PRINT)

Name: Chaplain Dr. Victoria A. Phillips-Dr. V

Address: 40 Rector st 9th Floor, MHP

I represent: Mental Health Project / Urban Justice Cent

Address: 40 Rector st 9th Floor

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: 02/06/23

(PLEASE PRINT)

Name: Jason Bowen

Address: W 149th St

I represent: CCIT / C4

Address: 315 2nd Ave

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: Karim Walker

Address: Van Sinderen Ave

I represent: SNP

Address: 123 William St.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Evelyn Graham-Nyansi

Address: West 26th street

I represent: Community Access + CCITNYC

Address: 17 Battery Place - NY 10004

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Nadia Chait

Address: 4 West 125th Street

I represent: CASES

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☑ in opposition

Date: 2-6-2023

(PLEASE PRINT)

Name: RICHARD WILLIAM FLORES

Address: WEST 47TH ST

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: 2/6/23

(PLEASE PRINT)

Name: Nadia Swanson

Address: 321 W. 125th st NY NY

I represent: The Ali Forney Center

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: 2/6/23

(PLEASE PRINT)

Name: Jessica Fear

Address: _____

I represent: VNS Health

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 2/6/23

(PLEASE PRINT)

Name: Kimberly George

Address: _____

I represent: Project Guardianship

Address: 320 Jay Street

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Sarah Blanco

Address: Midtown comm court

I represent: Midtown comm court / center for Justice Initiative

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: Feb 9 2022

(PLEASE PRINT)

Name: Joshua Stanton

Address: Bath Street Brooklyn NY 11214

I represent: Tirdof Cllesy (Jewish) with JAFEST + Torah

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____ oversight T2023-2843

☐ in favor ☐ in opposition

Date: 2.6.2023

(PLEASE PRINT)

Name: Ruth Lowenkron

Address: _____

I represent: New York Lawyers for the public Interest

Address: 151 W 30th Street #11 NY NY 10001

THE COUNCIL
THE CITY OF NEW YORK

Please allow me 30sec more time to speak.

Appearance Card

oversight T2023-2843

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

I am a peer and need reasonable accomodations

☐ in favor ☐ in opposition

Date: 2.6.2023.

(PLEASE PRINT)

Name: ChristinA Sparrock.

Address: Brooklyn NY 11217

I represent: Person-Centered Intervention Training.

Address: Same as above.

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: 2/6/2023

(PLEASE PRINT)

Name: FIONA O' GRADY

Address: 61 GRAMERCY PARK N. N4, NY 10010

I represent: THE SAMARITANS SUICIDE

Address: PREVENTION CENTER

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Casey STARR

Address: 61 Gramercy Park North

I represent: The SAMARITANS of New York Inc

Address: SUICIDE PREVENTION CENTER

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Director Michael Clarke - Director of Legislative Affairs

Address: NYPD

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: Chief Juanita Holmes - Chief of Training

Address: NYPD

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Chief Theresa Tobin - Chief of Interagency Operations

Address: NYPD

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: Janie Neckles

Address: _____ Manhasset, NY

I represent: NYC DOHMH

Address: 42-09 28th Street, LIC NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 2/6/2023

(PLEASE PRINT)

Name: Jason Hansman

Address: 253 Broadway

I represent: Mayor's Office of Community Mental Health

Address: 253 Broadway

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: 02/06/2023

(PLEASE PRINT)

Name: DR. OMAR FATTAL

Address: _____

I represent: NYC HEALTH & HOSPITALS

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: Chief Michael Fields

Address: Chief of EMS

I represent: FDNY - EMS Operations

Address: 9 Metrotech BK NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☒ in opposition

Date: 2/6/2023

(PLEASE PRINT)

Name: Beth Haroules

Address: _____

I represent: NYCLU (ACLU of NY

Address: 125 Broad St 19th fl NYC 10004

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: 2/6/23

(PLEASE PRINT)

Name: Lena Allon

Address: _____

I represent: Fordham House

Address: 425 W. 47th Street NY, NY 10036

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: Elena Landriscina

Address: 199 Water St, NY NY 10038

I represent: Legal Aid Society

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: 2/6/23

(PLEASE PRINT)

Name: SIYA HEGDE (THE BRONX DEFENDERS)

Address: NY, NY 10028

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☒ in opposition

Date: Feb 6 2022

(PLEASE PRINT)

Name: Ari Kadosh

Address: _____

I represent: CCIT / Community Access

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☒ in opposition

Date: 2/6/22

(PLEASE PRINT)

Name: Kate Whitemore

Address: Brooklyn, NY

I represent: self

Address: _____

Please complete this card and return to the Sergeant-at-Arms