NEW YORK CITY COMPTROLLER
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Safer for All

A Plan to End Street Homelessness for People with Serious Mental Illness in NYC

BUREAU OF POLICY AND ORGANIZING

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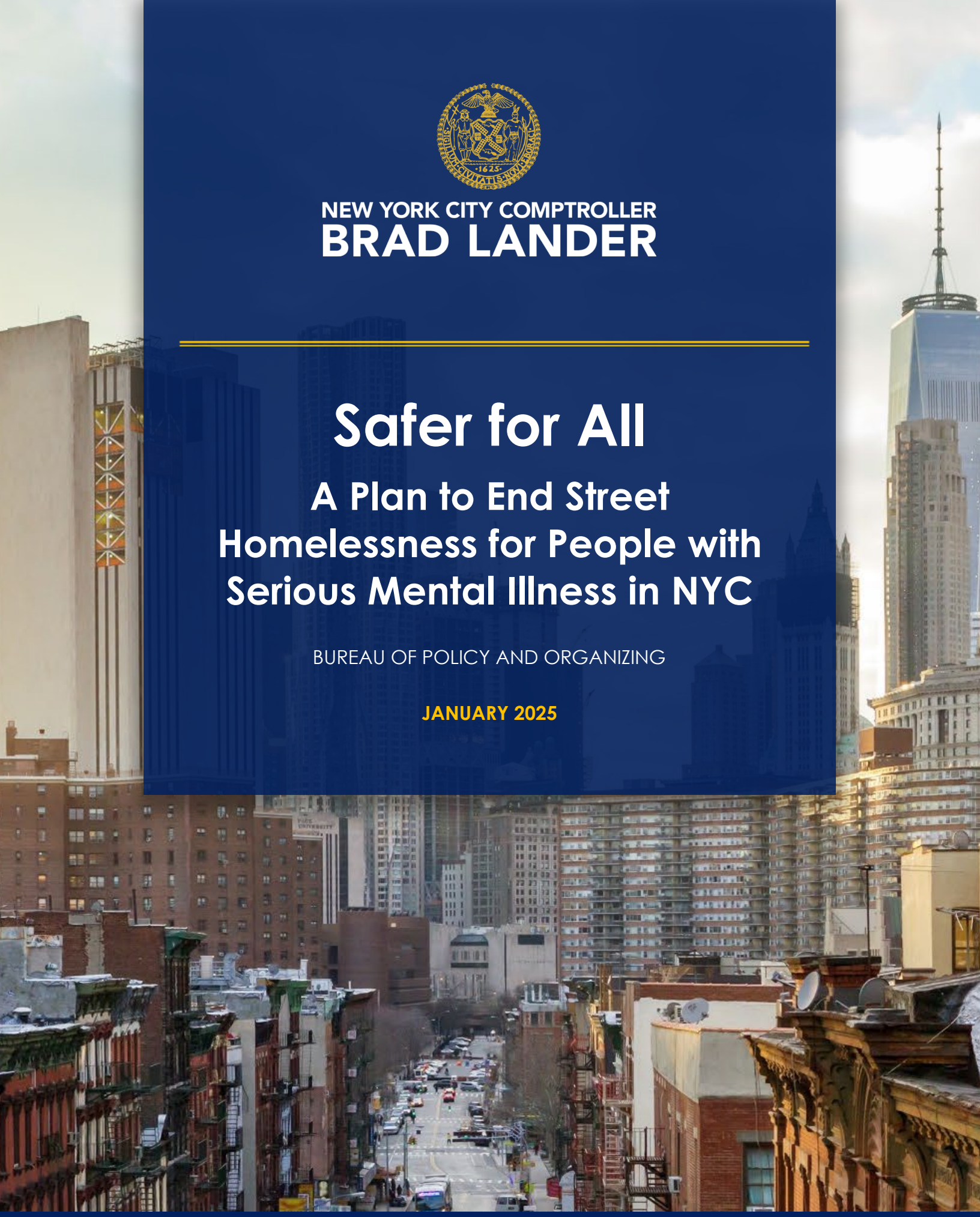

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Executive Summary

In the aftermath of the Covid-19 pandemic, a series of high-profile, random, and tragic acts of violence have heightened New Yorkers' attention to people living on the streets and subways with serious mental illness. Following the killing of Michelle Go in January 2022 by an individual with a long history of psychosis, 37 more people were pushed off subway platforms in just over a year.[1] In November 2023, New York Times reporters highlighted nearly 100 random attacks by mentally ill, homeless New Yorkers "failed by a system that keeps making the same errors."[2]

In recent weeks, the sense of crisis has been amplified by more heartbreaking incidents. On November 18, 2024, Ramon Rivera – who cycled on and off the streets with serious mental illness for years – went on a stabbing spree, killing 3 people in broad daylight in midtown Manhattan.[3] On December 9, a jury acquitted Daniel Penny of the killing of Jordan Neely, whose failures by the system were legion.[4] On Sunday, December 22, 2024, Debrina Kawam who was herself homeless was cruelly burned to death on an F train at the Coney Island station.[5] On New Year's Eve, another New Yorker was pushed onto the tracks into an oncoming train.[6] New Yorkers' sense of safety on subways and in their own neighborhoods has plummeted.[7]

In response to mounting safety concerns, New York City and State have launched a slew of initiatives and legislative efforts to confront the issue of street homelessness for people with serious mental illness. But the efforts are piecemeal. People continue to fall through the cracks and there is little public confidence that things will change.

The Adams Administration has ineffectively coordinated a Continuum of Care (CoC) – and the results are devastating. Outreach teams lose track of clients.[8] Hospitals release patients back to the street after a few hours because there aren't enough inpatient beds to treat them. Judges cannot refer people into programs proven to reduce recidivism and increase adherence to treatment because there are no slots.[9] Jails place just 3% of discharged people with serious mental health challenges into supportive housing.[10]

An audit by the Comptroller's office in 2024 of the City's Intensive Mobile Treatment (IMT) program for homeless New Yorkers with the most severe histories of mental illness found that the City inadequately measured whether the program was decreasing incarceration because of a lack of coordination among City agencies, that outcomes and treatment measures were inconsistent, and that placements into stable housing had declined precipitously.

Despite these persistent failures, evidence from other cities – and indeed, even from New York City – argues strongly that this crisis can be solved with more diligent leadership.

Data shows that there are approximately 2,000 people with serious mental illness at risk for street homelessness cycling through City streets, subways, jails, and hospitals. At that scale, a better-coordinated system is within the grasp of a city with the resources and capacity of New York. Indeed, the City is already spending billions on outreach, police overtime, city jails, shelters, and emergency hospitalizations, but City Hall has continuously failed to coordinate these efforts effectively to solve the problem.

At the heart of that better-coordinated system, this report centers a "housing first" approach, which evidence shows has had great success in Philadelphia, Houston, Denver, other cities throughout the United States and around the world, and even in New York City.[11] Housing first combines existing housing vouchers and service dollars to get people off the street and directly into stable housing with wraparound services.

Data shows that 70-90% of people experiencing street homelessness with serious mental illness will accept permanent housing with a coordinated outreach strategy, and that it will keep them stably housed, off the street, and better connected to the mental health services that will stabilize them.[12]

Of course, a strategy that is 70-90% effective does not work 10-30% of the time. For those instances, New York City will need better processes for mandated treatment. Sometimes, individuals need to be hospitalized, either voluntarily or involuntarily when they are a danger to themselves or others. For an effective continuum of care, New York should thoughtfully amend its laws to allow a wider range of medical professionals to place or keep individuals in hospitalization and required the consideration of an individual's full medical and behavioral history.

On any given day, there are approximately 1,400 people with serious mental illness detained in NYC jails, including Rikers Island. There is an urgent need to ensure these individuals are provided with adequate mental health care while they are in detention, and before they are discharged and return back to their communities. Instead, the City releases most of these individuals without receiving mental health treatment and without placement into housing, increasing the likelihood of returning to unsheltered homelessness.[13] In addition, individuals assigned by court order to "assisted outpatient treatment" (AOT) face significant challenges including homelessness. Without stable housing, adherence to the required treatment plans becomes more difficult, undermining the effectiveness of AOT programs.

In all these cases, ultimately individuals need to be connected to stable housing – when they are discharged from jail, when they leave the hospital, or while they are in AOT – or else they will simply return to the street, where they are far more likely to go without treatment and continue in a declining spiral. That's why a housing first approach is a central element of any effective plan.

With better coordination and management from City Hall, with a "housing first" approach that evidence suggests will work most of the time, and with more effective mandated treatment options when it doesn't, New York City can dramatically reduce – and even effectively end – street homelessness of people with serious mental illness.

This report offers the blueprint for how we can do it.

Key Challenges

Mismanagement from City Hall and lack of coordination between agencies leaves many people falling through the cracks.

Despite renewed focus from City and State leaders on the intersection of street homelessness and serious mental illness, the City has continuously failed to ensure the programs in place to serve this population are well-coordinated or managed. The City has spent approximately $300 million on outreach programs in each of the past three fiscal years but has failed to ensure these programs have the technology needed to track their engagements and routinely fails to notify outreach workers when clients are admitted and discharged for City hospitals and jails. State outreach programs including The Safe Options Support program (SOS), Subway Co-Response Outreach Teams (SCOUT), and The Partnership Assistance for Transit Homelessness (PATH) have shown promising results, but much of the data on their efficacy and operations are limited to what's available in press releases. Failure to track and share outcomes across the litany of outreach programs limits the ability of providers to coordinate care and undermines efforts to build trust, stabilize individuals, and connect them to services.

The IMT program presents a promising approach to treating the hardest-to-serve clients, but the City has failed to develop key performance indicators, effectuate inter-agency coordination, or track outcomes over time. The City's Behavioral Health Emergency Assistance Response Division (B-HEARD) program, which is intended to connect people in crisis to care, has largely failed to meet its goals. Police officers, who do not have the skills or specialized knowledge needed to deescalate situations or connect people to health services, remain the default response to the overwhelming majority of mental health crisis calls, without any mental health professionals present. Finally, the City's CoC, which is intended to coordinate homelessness programming, plays no meaningful role in strategic decision making and fails to include any representatives from the City's criminal justice and public health systems. Without clear goals, rigorous tracking of outcomes, or coordination across public agencies and service providers, people with serious mental illness continuously fall through the cracks, spiraling through crises and too often presenting a danger to themselves and others.

Significant barriers keep people from accessing mental healthcare.

The most effective way for someone to receive psychiatric care is for them to seek it voluntarily, but obtaining affordable voluntary mental health care in New York City is a significant challenge, especially for vulnerable New Yorkers at risk for street homelessness. In a 2023 survey of adults who had experienced serious psychological distress in the last year, 46% cited cost as a factor for why they were not able to receive treatment and 43% said they did not know where to go to get help.[14] Mobile Treatment Programs designed to connect those individuals to care have long wait

times and cannot provide tapered off-ramps for individuals, leaving participants in extremely resource-intensive programs for years on end, further constraining the capacity of the public health system. Medicaid rate cuts imposed by Former Governor Andrew Cuomo have driven closures of private hospital inpatient facilities in the face of low reimbursement rates, putting further strain on the public hospital system and deepening budget deficits.[15] A shortage of health care professionals, high caseloads, and low pay for contracted human service workers undercuts the efficacy of City programs, which struggle to attract and retain qualified talent.[16] The erosion of public funding and support for the City's mental health ecosystem has contributed directly to the crisis of street homelessness for people with serious mental illness, exacerbating barriers to mental health care for vulnerable populations. This dynamic creates a troubling paradox in which people in acute crisis are more able to access services than someone voluntarily seeking therapeutic treatment or support when their symptoms are easier and less expensive to treat.

Mandated mental health treatment can be difficult to effectuate and is constrained by a lack of appropriate residential facilities.

When individuals cannot or do not access voluntary mental health care, mandated programs play a critical role. However, involuntary treatment can also be difficult to secure or effectuate. State law prohibits psychiatric nurse practitioners, who have specialized expertise in providing care to patients struggling with mental health problems, to conduct evaluations. Existing law also fails to require consideration of an individual's full medical history, which can lead to practitioners releasing them without full knowledge of their condition. These gaps in State law constrain the hospital system's ability to conduct evaluations and secure treatment.

Mental health court diversion programs have proven effective in reducing recidivism, but program expansion is constrained by a lack of appropriate residential facilities. There are currently no residential facilities for people who have serious mental illness but do not have an active substance abuse problem operating in New York City, making placements of individuals experiencing homelessness with SMI a particular challenge.

On any given day, there are approximately 1,400 people with serious mental illness in City jails, where mental health services are critically inadequate.[17] Nonetheless, the Adams Administration has dragged its feet in constructing outposted therapeutic beds for individuals in detention by Department of Correction (DOC) who require a higher level of care that would benefit from better access to the services available in the hospital but do not require hospitalization.[18] None of the 360 beds announced in 2019 are online.

Lack of access to stable housing with support services leaves people with SMI cycling through crises.

Whether a person with serious mental illness is, at any particular moment, sleeping on the street, in a hospital, in a shelter, or in jail, they will need stable housing with wraparound support

services to stay off the street and succeed in treatment. The failure to provide pathways to stable housing with services leads many people to cycle from street to subway to hospital to jail, and back again, through repeated crises. Yet New York City's current programs overwhelmingly fail to focus on housing placement. In essence, we have a "housing last" system.

The Adams' Administration's homeless encampment sweeps, one of the Mayor's primary responses to street homelessness, connected just 3 people (0.1% of the 2,308 removed) to permanent housing during the most recently audited period.[19] Homelessness persists for individuals in mobile treatment programs, with the percentage of clients who were able to retain stable housing in the City's IMT program dropping from 44% to 37% over a 21-month period.[20] Hospitals, emergency rooms, and Comprehensive Psychiatric Emergency Program (CPEPs)[a] do not adequately connect individuals to housing at discharge; available data indicates that just 25% of qualified people discharged from State Psychiatric Centers, transitional living residences, hospitals, and treatment programs were accepted in supportive housing upon discharge.[21] And the numbers are even worse in jails, where the City routinely fails to fill out supportive housing applications for individuals with an SMI diagnosis set to be discharged, as legally required, and successfully places just 3% of qualified individuals into supportive housing.[22]

The City's failure to connect individuals to housing is due to a failure to make stable housing a primary focus, the lack of coordination between institutions, and a shortage of supply of supportive housing. While supportive housing starts have rebounded after the Covid-19 pandemic, the NYC 15/15 initiative has delivered fewer than 4,000 of the promised 15,000 units as of May 2024 and it has taken on average, approximately six months to match eligible residents to a new unit for each of the last five fiscal years.[23] [24]

However, despite a lack of overall supply, vacancies in supportive housing persist. The hardest to rent units are older SRO (single room occupancy) units and units that require tenants to share a living space with a roommate. Many of the individuals who have successfully navigated the application processes and program requirements gauntlet would prefer a newly constructed apartment with a separate bathroom and building amenities and often reject these units or do not show up for interviews.[25] Reporting and information from supportive housing providers indicate that there may be as many as 4,000 vacant units of supportive housing, many of which have been vacant for months, even years. These persistently vacant units would be enough to house the majority of seriously mentally ill New Yorkers currently sleeping on the street.

Finally, New York State has steadily reduced its support for shelter and failed to fill the gap in housing subsidies. The State's contribution to the City's shelter system plummeted from 47% in 2007 to just 6% as of Fiscal Year 2024, putting enormous strain on the City's budget to meet the right-to-shelter mandate which is grounded in the State constitution. In addition, the State has

[a] CPEP (Comprehensive Psychiatric Emergency Program) is a 24/7 specialized psychiatric service in New York, providing extended observation for immediate crisis care, evaluation, and treatment for individuals of all ages experiencing acute mental health issues. There are 12 CPEPs in New York City funded by the NYS Office of Mental Health (OMH).

failed to pass the Housing Access Voucher Program (HAVP), designed to increase subsidized exits from shelter, which has forced the City to expand its CityFHEPS (Family Homelessness and Eviction Prevention Supplement) program and exacerbated the homelessness crisis.

Recommendations

Improve City Hall management and coordination across agencies and outreach programs, with a diligent focus on outcomes.

- **Improve management at City Hall:** Create a dedicated team at City Hall that drives resource deployment and decision-making citywide, with a focus on stabilizing and housing the highest risk populations living on the streets. Set clear, ambitious goals for ending street homelessness and rigorously track short-, medium-, and long-term key performance indicators. Regularly conduct program evaluations to identify gaps in services and hone successful models to drive program modifications and expansion.

- **Empower and expand the City's Continuum of Care to facilitate program implementation and improve coordination:** Require participation from the City's criminal justice, public health, and mental health systems in the City's CoC. Implement City Hall priorities including resource allocation and deployment, budget modifications, issuance of requests for proposals, and the initiation of contract modifications to adjust and expand programs as needed. Facilitate coordination between the City's jails and hospitals with the City's housing, homelessness, and mental health services providers. Regularly report to City Hall and agency leadership on the status of implementation, program challenges, priorities and recommendations for improvements.

- **Improve and expand proactive subway and neighborhood outreach teams:** Expand promising outreach programs for people with SMI including SOS, SCOUT, and PATH. Ensure outreach teams are provided with the resources they need to build long-term trust with clients. Set clear and consistent programmatic short- and long-term goals including treatment adherence rates and placements into permanent housing. Improve StreetSmart to create a centralized real-time data platform that outreach providers can use across City and State teams. Ensure integration with the Department of Homeless Services (DHS) CARES (Client Assistance and Rehousing Enterprise System) to ensure diversion strategies and client outcomes can be tracked. Work to better integrate these systems into the State's Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) used by healthcare providers to ensure timely data reporting systems across institutions and nonprofits to prevent people from falling through the cracks.

- **Restructure the City's framework for mental health emergency response, to always include mental health professionals, and better distinguish between crisis and non-crisis interactions:** Deploy mental health professionals and peer responders to 100% of

911 mental health crisis calls through a new citywide, 24-7 program modeled on the Crisis Assistance Helping Out on The Streets (CAHOOTS) model, incorporating best practices to mental health crisis response. Deploy police officers alongside those mental health professionals in cases where 911 operators believe there is a risk of violence. Require all in-service police officers to complete mental health response training, ensuring comprehensive coverage across the department and mandate annual refresher courses to maintain and enhance their skills. Implement a standardized curriculum for all 911 call center operators to ensure operators can assess and triage mental health crisis calls effectively. Increase public transparency and rigorously track outcomes through the creation of a centralized database for all mental health crisis responses. Create an independent oversight team to monitor and evaluate the mental health crisis response system.

Create a "Housing First" program with robust wraparound support services for people with serious mental illness experiencing street homelessness.

- **Create a large-scale "Housing First" program with robust wraparound services for people with serious mental illness experiencing street homelessness**: Expand and adapt New York City's recent Street-to-Home pilot operated by Volunteers of America of Greater New York, which moves individuals experiencing street homelessness directly into vacant SRO units and provides wraparound support services. Scale up the program by bringing in additional supportive housing providers, either through the issuance of a Request for Proposal or through negotiating contract modifications of existing service contracts. Ensure the coordination of services between mobile treatment programs and supportive housing staff for clients placed in housing first units who are receiving treatment services from existing City or State mental health teams. Task the CoC to fully incorporate a Housing First model for street homeless individuals with SMI into the City's existing Coordinated Assessment and Placement System and ensure wider adherence to Housing First principles. Establish shared metrics across providers and rigorously track outcomes of the model.

- **Fulfill the NYC 15/15 commitment to build supportive housing and create more supportive housing through a NY/NY IV agreement:** Implement the recommendations to increase efficiency at the Department of Housing Preservation and Development (HPD) made by the Office of the Comptroller in a February 2024 Report, *Building Blocks for Change.* Work with the Supportive Housing Network of New York to implement its recommendations to fulfill the NYC 15/15 commitment, including the reallocation of unawarded scattered site units, the enhancement of NYC 15/15 contract rates and capital subsidy, and the development of a supportive housing preservation program. The City and State should work together to make a shared goal to increase City and State funding for more supportive housing through a new NY/NY IV agreement.

- **Provide supportive housing placements to people with serious mental illness discharged from City jails:** The City should set and publicly track a citywide policy to successfully place 100% of people discharged from City jails with serious mental illness into permanent, supportive housing, and rigorously track outcomes of discharged individuals with SMI. The New York City Council should immediately approve the Just Home program to bring online 83 new housing units, including 58 units of critically needed supportive housing for justice-involved people with complex medical needs, some of whom may have SMI. The City and State should baseline and increase funding for justice-involved supportive housing for people with SMI. City Hall should centralize and rigorously track outcomes of discharged individuals with SMI including housing stability, recidivism rates, and health improvements.

- **New York State should do its fair share to confront the City's homelessness crisis:** Reverse Cuomo-era budgeting that shifted the cost of single adult shelter onto the City, making $500 million more available for increased mental health services, better wages, and improved shelter conditions including expanding the number of purpose-built, smaller scale mental health shelters. Increase State funding for the NY/NY-funded supportive housing units to protect them from market pressure. Pass the HAVP legislation to allocate $250 million to housing vouchers, with 50% of the allocation for New York City set aside for individuals currently experiencing homelessness.

Expand and improve involuntary and court-ordered treatment and secure detention programs.

- **Close gaps in State law around involuntary hospitalization and AOT to ensure more people receive the care they need:** The State Legislature should expand the range of professionals authorized to evaluate individuals for involuntary hospitalization and AOT to include psychiatric nurse practitioners (as proposed in the Harness Expertise of Licensed Professionals, or H.E.L.P Act, sponsored by Senator Hoylman and Assemblymember Lasher). Require hospital administrators to notify community mental health providers who have previously treated a patient when the patient is admitted to a hospital. Require practitioners who are evaluating an individual for involuntary hospitalization and treatment to take in account the individual's full medical history.

- **Expedite and expand secure, outposted therapeutic beds:** Immediately bring online the 100 beds under final stages of construction at Bellevue. Work with the State Commission on Corrections to expedite final review and approval of the facilities planned at Woodhull and North-Central Bronx hospitals, bringing the total to 360 beds. Increase the City's current commitment to ultimately bring the total number of therapeutic beds to 1,500, as recommended by the Independent Rikers Commission.

- **Increase the capacity and efficacy of Mental Health Courts:** Increase funds for court-based mental health diversion programs to improve case management and facilitate program administration. Guarantee individuals referred into Mental Health Court

placements in therapeutic settings including secure and semi-secure residential facilities or, if appropriate, supportive housing units depending on the severity of the charge and the individual's circumstances. Increase funding for District Attorney-led diversion programs across all five boroughs. Develop a consistent citywide evaluation framework for mental health courts to centralize data collection and track short- and long-term outcomes to inform program expansion and improvements over time.

Both the City and State must invest in the capacity of the mental health system.

- **Reverse state-level funding cuts for New York City's mental health system:** Increase Medicaid reimbursement rates to shore up the City's public hospital system and incentivize private health care providers to provide adequate mental health care to the 3.5 million New Yorkers who are covered by Medicaid.

- **Invest in the City's mental health and human services workforce:** Guarantee workers at City-contracted nonprofit human service and mental health providers a living wage and regular cost of living adjustments to reduce worker turnover and burnout. Expand tuition assistance and loan relief programs for part- and full-time mental health workers employed by City and State agencies. Expand and empower the city's peer workforce in line with the Colorado Behavioral Health Administration's Crisis Professional Curriculum. Introduce a CUNY rotation for social work and psychology students at clubhouse programs. Consider introducing sabbatical options for mental health care workers into City contracts after a certain length of service with the City of New York to reduce workforce burnout and turnover in extremely high-stress jobs.

- **Invest in and adapt mental health care services for people with SMI to fully integrate them into the new Housing First approach and related programs:** Create more flexibility in IMT, ACT, and other mobile treatment programs to allow for services to be tapered over time as clients stabilize through step down programs, allowing for a reduced staff to client ratio for some patients and increasing the number of individuals who can be served and reducing wait times. Expand the State's Rehabilitative and Tenancy Support Services program to provide more intensive and step-down mental health treatment to individuals in supportive housing. Coordinate care for AOT participants with existing mobile treatment programs, to increase efficacy and improve outcomes. Increase funding for the hiring and retention of psychiatric nurse practitioners at City-funded community health centers, public hospitals, and mobile treatment and crisis response teams.

History

In the early 19th century, poor individuals with mental illness were confined to alms and poor houses, which did not have separate living facilities or treatment programs for those with psychiatric disorders. Conditions in these facilities worsened as overcrowding grew, and individuals who exhibited anything considered violent behavior were often restrained and shackled for extended periods of time.[26] The country's first publicly funded mental hospital opened in 1839 on New York City's Roosevelt Island. The design plans were based on growing models of mental health institutions in Europe and the theories of moral treatment, but they were never fully realized; the conditions and treatment of individuals was poor from the start [27] Eugenics also played a role in the establishment of these facilities and was reflected in the treatment of those with mental illness and disabilities, as some medical professionals sought to 'improve the stock of humanity' by separating individuals with mental illness or disabilities—especially those from marginalized socioeconomic or ethnic groups—from the general population.[28]

In response to advocates like Dorothea Dix highlighting the poor treatment of the mentally ill, the State Legislature passed the Willard Asylum Act in 1865, which required the removal of all patients diagnosed with "insanity" from local poorhouses. The first state asylum, the Willard Asylum for the Chronic Insane, was built shortly after the passage of the bill, specifically for those deemed "incurable."[29] Dozens of additional public psychiatric hospitals and facilities were built during the second half of the 19th century and by the 1950s, New York had over 30 state and city public mental health institutions. [30] While many of these institutions were purpose-built, the physical conditions of the buildings, and patient living conditions deteriorated severely over time. The infamous *Life* magazine article *"Bedlam 1946"* by Albert Q. Maisel, exposed the dire conditions during the 1940s. The article brought national attention to critical issues such as insufficient wages that hindered staff recruitment, severe understaffing, long work hours, and widespread abuse—including patients being restrained, beaten, drugged, starved, and neglected in overcrowded facilities.[31]

By the mid-20th century, investigative journalism, civil rights activism, including a growing disability rights movement, and expanded public awareness exposed the systemic failures of institutionalization. Advocates, including families of individuals living in these facilities, disability rights organizations, and mental health reformers, demanded more humane treatment and better, community-based alternatives. Additionally, the emergence of new antipsychotic medications such as Thorazine in the mid-1950s fueled optimism among policymakers, psychiatrists, and advocates that most people with serious mental illness could live independently or with the support of family in community settings.[32]

Through these efforts and advancements, the National Community Mental Health Act (CMHA) was passed in 1963, marking a pivotal moment in the movement towards community-based care. The legislation sought to reduce reliance on large state-run mental institutions and shift individuals with serious mental illness into more integrated living arrangements. Under the oversight of the National Institute of Mental Health (NIMH), the CMHA provided federal grants

to states for constructing and staffing community facilities.[33] The act envisioned centers offering five essential services: consultation and education, inpatient care, outpatient clinics, emergency response, and partial hospitalization.[34]

While the initial plan focused on comprehensive community support, the rollout was fraught with challenges. States often prioritized closing costly state hospitals without investing in the needed community infrastructure. Every state, including New York, participated in the initiative, with $2.66 billion spent on Community Mental Health Centers (CMHCs) nationally by 1981. However, despite initial goals to establish over 1,500 centers nationally, only 781 CMHCs were ever created, and none were adequately funded for long-term operation.[35] [36] Additionally, while medications like Thorazine can stabilize symptoms for some individuals, providers have since stated that there was an overly optimistic belief that pharmaceutical innovations could supplant the wraparound support services that many individuals need in addition to medication.[37]

Deinstitutionalization accelerated after the adoption of Medicaid and Medicare in 1965, which fundamentally reshaped the financial landscape of mental health care. Medicaid incentivized states to discharge patients from state-funded institutions, such as state hospitals, to community-based settings, as Medicaid excluded payment for care in Institutions for Mental Diseases (IMDs). IMDs are defined under federal Medicaid law as a hospital, nursing facility, or other institution with more than 16 beds that is primarily engaged in the care and treatment of individuals with mental illnesses, including severe psychiatric disorders or substance use disorders.[38] This further incentivized states to close institutions and transfer patients to community hospitals and nursing homes in order to share the financial burden of treatment with the federal government. As a result of these measures, populations declined at state-run psychiatric institutions throughout the country, with the number of patients in state hospitals dropping nationally from 560,000 in 1955 to 193,000 in 1975.[39] In New York State the population in State residential facilities dropped from about 95,000 in 1955 to 11,286 by 1994.[40] [41]

The Reagan administration further reduced federal support for mental health, transforming existing funding streams into block grants under the Omnibus Budget Reconciliation Act of 1981 with the goal of reducing “administrative waste” and providing states with more flexibility to allocate funding according to local needs.[42] The shift to block grants coincided with broader budget cuts, which reduced federal spending on mental health and social welfare programs by 25% — an estimated reduction of $22 billion.[43] These cuts undermined the sustainability of the relatively small number of community-based mental health care facilities that were built following the passage of the CMHA, as the operational funding for these programs increasingly became the responsibility of individual states. As states struggled to fill budget gaps, staffing shortages emerged, services were reduced, and community mental health centers had to implement higher fee structures to people seeking care.[44]

In addition to the reduction of community-based services, the number of inpatient psychiatric treatment beds has been greatly reduced over the past 30 years. Data from MergerWatch, an advocacy group focused on patient rights during hospital mergers, show that between 1997 and 2018, over 40 hospitals in New York State ceased inpatient psychiatric services, 15 of which were in New York City.[45]

One of the driving factors towards hospital closures and the reduction of inpatient beds in New York was former Governor Andrew Cuomo's Medicaid Redesign Team, which promoted cost-saving measures that included closing "unprofitable hospitals." In response to significant policy changes and budget cuts to Medicaid and Medicare during the Bush administration, in 2014, former Governor Andrew Cuomo introduced the "Transformation Plan," which included sweeping reforms of the New York's mental health system based on recommendations from the Medicaid Redesign Team (MRT).[46] The plan sought to shift the focus of New York's mental health care system from inpatient psychiatric hospitalization to community-based services. This involved cutting nearly one-third, over 800, of the remaining state-run psychiatric hospital beds for children and adults and redirecting funds into outpatient programs, crisis intervention teams, long-term housing, and expanded mental health clinics and reducing reimbursement for longer inpatient stays. As of December 2024, there are 3,643 adult, including 207 for justice-involved individuals, and 309 child inpatient psychiatric beds in New York City.[47]

For each closed bed, the state committed to reinvesting $110,000 annually in community-based care. These investments fell far short of addressing the level of need and removed a crucial component of a robust, successful public mental health system. What's more, the reinvestment in these services through the closure of inpatient beds, came alongside significant State budget cuts to housing and human services, undercutting the impact of the investment.

Former Governor Cuomo's Transformation Plan aimed to reduce hospitalizations, but it inadvertently increased reliance on emergency care. Emergency room visits by Medicaid-enrolled children rose 25% in five years, while access to behavioral health services stagnated. The reduced number of inpatient beds, combined with high turnover in outpatient clinics, inflicted long-term damage on children's mental health services, leaving families with limited or inadequate care during critical periods of development.[48] By closing hospitals and reducing access points without a comprehensive plan to expand alternative services, the system forced individuals into emergency care settings ill-equipped to address their ongoing mental health needs, just as inpatient psychiatric beds had been reduced, exacerbating the crisis and creating a cycle where people are trapped in reactive care rather than receiving the supportive, preventative treatment they require.

The plan's shortcomings mirror the fate of the CMHA of 1963, which similarly sought to shift care to a more community-based model but ultimately increased underfunding and starved our city's mental health system. Much like the CMHA, Andrew Cuomo's plan lacked the sustained financial and operational support needed to realize its goals, overburdening public mental health hospitals while failing to provide the resources needed for community-based care.

Defining the Population

Most individuals and families experiencing homelessness in New York City seek temporary refuge within the City's shelter system. While there are many problems with the shelter system, and the path to permanent housing is agonizingly long for many households, New York's "right to shelter" means that the vast majority of homeless New Yorkers are able to sleep with a roof over the head, are not exposed to the elements, and have at least some access to food, health care, and services.

Despite accounting for only a small fraction of the overall population of homeless New Yorkers, individuals living on the street are the dominant face of homelessness. The 2024 annual Homeless Outreach Population Estimate (HOPE) count estimated that there were 4,140 individuals in New York City living on the street, in parks, or on the subway on January 23, 2024. Individuals experiencing street homelessness are more likely to be chronically homeless, have higher rates of serious mental illness, substance use disorders, and other severe health problems than homeless families in the shelter system.[b] People experiencing street homelessness with serious mental illness are the most visible manifestation of the failures of our healthcare and housing system.

Collecting accurate data about this population is notoriously difficult given the transient nature of living on the street, but there are several sources that provide a high-level estimate of the number of people in New York City who are living with a serious mental illness and currently experiencing unsheltered homelessness.

The United States Department of Housing and Urban Development (HUD) requires local governments to conduct an annual point in time count to determine how many people are experiencing street homelessness on a single night during the last week of January. The 2024 HOPE count found that there were 4,042 and 4,140 people experiencing unsheltered homelessness in New York City on January 23, 2023, and January 23, 2024.[49] This is a 75% increase from 2021, when the number of people living on the street decreased to a twelve year low of 2,376 due largely to the provision of individual private shelter rooms, which was temporarily enacted during the COVID-19 pandemic.

HUD publishes additional data, that includes the rate of people experiencing homelessness that are living with a serious mental illness (SMI), defined as a mental, behavioral, or emotional disorder that causes significant functional impairment, greatly disrupting or limiting one or more

[b] While those living unsheltered on the street have higher rates of mental health and substance use disorders, it is important to not paint a diverse population with a broad brush or assume that every individual requires the same intervention. A client centered approach to outreach and a broad array of permanent housing options should be made available to individuals experiencing street homelessness in order to better match services and housing placements to each individual's needs and preferences.

major life activities.[c] SMI diagnoses include conditions such as schizophrenia, bipolar disorder, and major depressive disorder. In 2023, the last year for which this data is available, 24% of people experiencing unsheltered homelessness In New York City were estimated to be living with a serious mental illness, or approximately 984 individuals.[50]

Many advocates criticize the point in time counts as undercounts. The Coalition for the Homeless cites the outreach numbers from the City's end-of-the-line subway program to illustrate the discrepancy: between May 2020 to January 2022, 9,231 unique individuals accepted offers of transportation to drop-in centers and various types of shelters.[51] However, this count likely includes many individuals who briefly experienced unsheltered homelessness and were able to quickly enter the shelter system or find other housing options after being connected to services.

The New York City Council passed Local Law 217 in 2017, which requires the Department of Homeless Services to publish a monthly report on the City's street outreach efforts. As of September 30, 2024, there are 2,867 people that have been confirmed to be experiencing unsheltered homelessness who are currently engaged with a Homeless Outreach & Mobile Engagement Street Action Team (HOME-STAT) and included in the City's 'by name list' of street homeless individuals. By name lists are a national best practice as they allow for cross-agency case-conferencing for homeless individuals who may be cycling through different City institutions and over time can help city officials identify patterns and solve for barriers in people finding permanent housing. Some of these individuals are in the IMT, ACT, or other service programs described below.

There is also a population of people detained at City jails with serious mental illness. The portion of people with serious mental illness has increased rapidly since the outset of the pandemic from just 14.92% in February of 2020 to 21.15% as of September 2024, or approximately 1,400 people.[52] The risk of homelessness among individuals with mental health issues post-incarceration is significant. According to the Rikers Island Longitudinal Study (RILS), individuals with histories of mental illness were more than twice as likely to experience homelessness or reside in temporary housing after release compared to those without such histories.[53]

While precise data on homelessness risk for individuals with mental health issues at Rikers is limited, the high prevalence of mental health diagnoses, combined with systemic housing barriers, suggests that a substantial portion of this population is at significant risk for homelessness upon release. Approximately 700 individuals or families discharged from City jails, in Fiscal Year 2024 were determined to be eligible for supportive housing by the City's Human Resources Administration (HRA).[54] Given the criteria for supportive housing eligibility, it is safe

[c] HUD uses the term "severe mental illness," but the preferred term among behavioral health providers and mental health advocates is serious mental illness. For consistency, the term serious mental illness (SMI) is used throughout this report from the Office of the NYC Comptroller.

to assume that many if not most of the 700 individuals or families have SMI and are at significant risk for homelessness.[d]

There are 3,643 inpatient psychiatric beds in New York City, including 850 located on State Psychiatric Center hospitals.[55] While there is no data available on the rate of homelessness for this population, the New York State Office of Mental Health reports that just over 8% of people who received some form of treatment from the State's public mental health system were either currently homeless or had experienced homelessness in the past six months. If this rate is applied to the number of people currently receiving treatment, there may be close to 300 people at risk for homelessness once they are discharged.

The Office of the New York City Comptroller estimates that there are approximately 2,000 individuals with serious mental illness currently experiencing street homelessness, or who are currently in a correctional or healthcare facility in New York City and at risk of unsheltered homelessness following their release.[e]

[d] The New York City Department of Social Services (DSS) report pursuant to Local Law 3 of 2022 identifies 717 individuals or families determined eligible for supportive housing while in "correctional facilities." This category predominantly refers to New York City Department of Correction (DOC)-managed jails, as these facilities are the primary detention settings intersecting with supportive housing systems in New York City. Other correctional settings, such as juvenile detention centers or hospital prison wards, may be included but are not likely to represent a significant portion of this population.

[e] There are significant limitations in estimating the true number of individuals with serious mental illness at risk of unsheltered homelessness. Limitations in publicly available data, underreporting of mental health conditions, and gaps in tracking individuals transitioning between correctional, healthcare, and housing systems can contribute to an incomplete picture. Additionally, individuals who do not engage with formal systems or services may be excluded from official counts, further obscuring the scope of the issue. This estimate is based on the public data that is available: approximately 1,000 individuals currently living on the streets and subways with serious mental illness; 700 individuals in City jails with SMI at risk of street homelessness upon discharge; and 300 people with SMI at risk of street homelessness in hospital settings. This report makes several recommendations relating to coordinated data systems to improve the quality and reliability of this public data over time.

Key Challenges

Mismanagement from City Hall and lack of coordination between agencies leaves many people falling through the cracks.

Despite renewed focus from City and State leaders on the intersection of street homelessness and serious mental illness, the City has continuously failed to ensure that the programs in place to serve this population are well-coordinated or managed. Without clear goals, rigorous tracking of outcomes, or coordination across public agencies and service providers, people with serious mental illness continuously fall through the cracks, spiraling through crises and too often presenting a danger to themselves and others.

Incomplete tracking and technology barriers limit the efficacy of outreach and follow-up.

Street outreach programs play a critical role in reaching and building trust with people experiencing homelessness with serious mental illness, but the programs struggle to measure and define success and fail to connect people living on the street directly with stable housing.

Over the past several fiscal years the City of New York has spent approximately $300 million annually on outreach services and the operation of drop-in services. HOME-STAT was created in 2014 by the de Blasio administration to create one system through which City employees and contracted not for profit organizations conducted outreach to individuals experiencing unsheltered homelessness.

These outreach teams proactively canvass streets and subways to connect people experiencing unsheltered homelessness to services, in addition to responding to 311 calls about people experiencing homelessness. A larger goal of HOME-STAT, as detailed in the 2017 *Turning the Tide on Homelessness* report was to find every person living on the streets of New York City to build a by-name list.[56] A by-name list of individuals experiencing homelessness is a national best practice, as it allows for increased coordination of care across the various institutions and agencies in which an individual experiencing unsheltered homelessness may interact. The creation of the by-name list of individuals experiencing street homelessness has likely increased the ability for agencies, including Health + Hospitals (H+H), Department of Correction (DOC), Department of Homeless Service (DHS), and New York State Office of Mental Health (OMH) to coordinate care for clients. However, conversations with key stakeholders and an audit conducted by the Office of the New York City Comptroller indicate that significant gaps in coordination remain.

The City of New York launched StreetSmart in 2017. StreetSmart is a confidential data-sharing application that allows outreach workers to collect and access critical information about street

homeless clients. The application was designed to allow for outreach workers in the field to see the other interactions that an individual may have had with another case worker and to be able to request additional support from managers or agency staff. However, functional issues have caused many outreach workers to develop more flexible, secondary tracking systems that limit the effectiveness of the program and hinders data quality. Additionally, an August 2023 audit from the Office of the New York City Comptroller found that despite the introduction of this technology, DHS still does not have a single data system for tracking all engagement with street homeless individuals due to a lack of integration between StreetSmart and CARES. CARES remains the agency's system of record, through which an individual's medical, substance use, and housing history as well as their access needs for shelter and housing is tracked over time.

The audit also found that DHS does not measure success by diversion strategy, nor does it track in aggregate the number of clients that accepted services such as substance use, mental health, medical or employment services. The agency also does not record the outcomes that may result from individuals accepting those services, nor returns to shelter after one year. Despite robust access to internal data, the Comptroller's auditors could not determine the percentage of engagements that resulted in temporary placements or permanent housing, indicating that it is not just that this data is not made public, but that it does not exist.

DHS accepted the auditor's recommendation to integrate StreetSmart and CARES to better track engagement with street homeless clients and measure the success of outreach efforts in connecting those individuals to permanent housing. DHS indicated during the audit that this integration was already in process, but as of January 2025, the recommendation had not yet been implemented.

New outreach programs have been launched, with promising results, but thus far little coordination, transparent data, or outcomes reporting.

Starting in 2022, New York State began expanding their support for outreach teams. SOS teams, consisting of medical professionals and social workers, are meant to build relationships with clients over time and connect them with treatment and support services. Between April 2022 and May 2024, the teams had about 27,000 outreach encounters.[57] In November 2024, a press release noted that the fifteen SOS teams canvassing throughout the five boroughs, including both streets and subways, had "helped find permanent housing [for] nearly 620 individuals, including 133 that were placed in OMH-licensed housing."[58]

The MTA and the City have also launched two co-response outreach programs. The Partnership Assistance for Transit Homelessness (PATH) and Subway Co-Response Outreach Teams (SCOUT) program supplement each other, with the SCOUT focusing on daytime outreach and PATH teams working overnight. SCOUT launched in October 2023 and PATH teams started working in August 2024. Both operate entirely within the City's subway system and are comprised of a clinician and two MTA police officers. According to an August 2024 *New York Times* article, SCOUT's daytime teams saw 99 people voluntarily accept shelter, 26 people voluntarily accepted hospital

assessment, and 24 were involuntarily transported for psychiatric assessment through mid-August.[59] The State aims to expand to ten teams in 2025 through a $20 million investment.[60]

SCOUT, PATH, and SOS have shown promising results, but much of the data is limited to what's made available in press releases and while the engagement numbers have been growing, some of the most critical data is harder to access, including long-term outcomes. It remains unclear how many total people remained in shelter, accessed stable housing, or received inpatient psychiatric treatment. There is also no public data on outcomes such as adherence to treatment plans over time. Additionally, it is unclear how or whether these State programs are tracking and sharing engagement data with the City's robust system of street outreach teams that have been in place for several years and developed relationships with overlapping populations.

The City does not adequately track or publish metrics on its Mobile Treatment Programs.

New York City and State offer several programs intended to serve individuals with mental health conditions who are unable to connect or stay connected to psychiatric services provided at a fixed location. Department of Health and Mental Hygiene's (DOHMH) Single Point of Access program helps providers connect individuals with serious mental illness to treatment services that best accommodate their needs. Referrals can come through homeless services organizations, inpatient or outpatient healthcare providers, the correctional system, or through other community-based organizations. There are five central programs operated in partnership between the City and State: Non-Medicaid Care Coordination (NMCC); Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (FACT); Shelter Partnered ACT (SPACT); and IMT. (See Appendix A for a description of each program.) As of December 9, 2024, the percentage of individuals enrolled in ACT on AOT (court-mandated outpatient treatment) in New York City is 24%.[61]

While most of these programs serve individuals who have experienced homelessness and housing precarity at some point in their lives, the IMT program has the most comprehensive services and is designed specifically to serve individuals experiencing homelessness with serious mental illness.[62]

The City's IMT program presents a promising approach to treating the hardest to serve clients, many of whom are living on the street or cycling between the shelter system. As of November 2024, 31 IMT teams provide 927 clients with support and treatment including medication and connections to housing and additional support services.[63] Practitioners assert that this program has been successful at treating the hardest to serve clients, particularly those who have experienced significant trauma and systemic discrimination, and who have not been served by other treatment modalities through the development of innovative, long-term relationship building to help people change and grow over time.[64]

Though this relatively new program model has shown promising results, a recent audit of the IMT program from the Office of the New York City Comptroller found that the City has failed to establish clear standards of treatment or goals for medication adherence. A sample review of the program revealed that client retention rates in the program are remarkably high—reaching up to 98%—however, only 41% of clients were seen by a psychiatric care practitioner at least three out of every four months they remained in the program. Furthermore, just 29% reportedly adhered to their prescribed medication regimens regularly.[65]

DOHMH has also failed to track participants' incarceration outcomes for over 18 months due to difficulties coordinating with the Department of Correction to obtain participant criminal activity data. Staff shortages and challenges posed by the COVID-19 pandemic were also cited as factors restricting DOHMH's capacity to track this information. Unlike the State's ACT program, which publishes real-time data on program participants, the City does not publish any data on IMT – even IMT program providers do not have access to the data needed to assess or evaluate the program over time.

In response to the audit, IMT providers countered that the IMT program provides much-needed flexibility that serves to curb workforce burnout and creates capacity for building the trust needed to stabilize patients in the long-term, which can be difficult to track quantitatively.[66] The City's failure to provide IMT teams with resources, coordination, and metrics for success ultimately undermines this promising new approach. Efforts to expand and increase resources for the IMT program will require rigorous monitoring and a balanced framework for program evaluation that integrates both qualitative and quantitative metrics.

The City's emergency response to mental health crisis calls too often fails to connect New Yorkers to mental health professionals.

When a New Yorker calls 911 to report someone in need of mental health crisis support, they should feel confident that the person will receive help from mental health professionals. Unfortunately, the NYPD remain the default response. While there has been an effort to train police officers, they are not behavioral health specialists, leaving them without the skills or specialized knowledge needed to deescalate situations or connect individuals to appropriate medical services. The NYPD began offering Crisis Intervention Training (CIT) in 2015, and it is now included in the Police Academy curriculum, making it mandatory for all recruits. However, for in-service officers, participation in CIT remains incomplete. Currently, approximately 50% of NYPD officers have completed this training, leaving a significant portion of the NYPD untrained in crisis intervention techniques.[67]

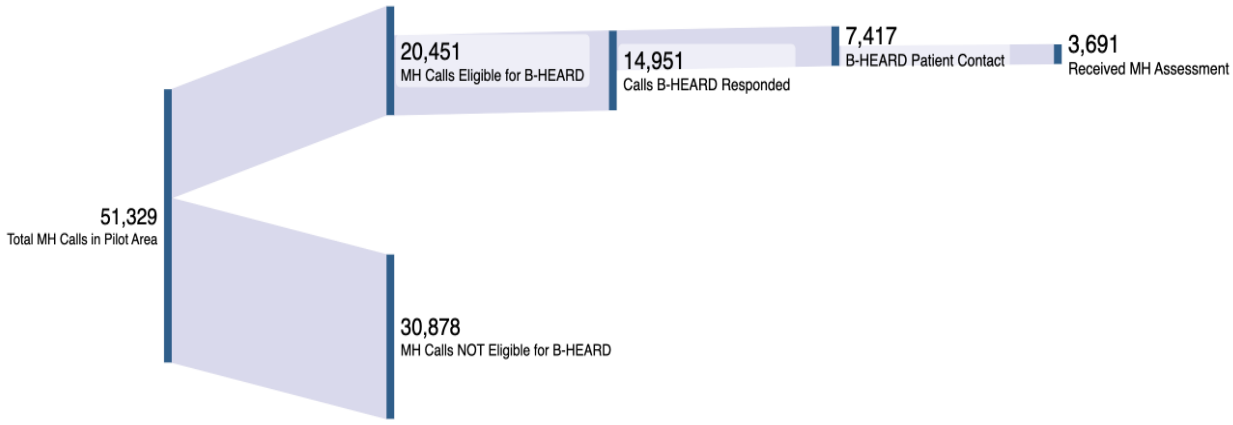
Too often, police interactions lead to the tragic killing of individuals in mental health crisis, which further dissuades New Yorkers from calling for help when people need it most. The City initiated two programs to better connect individuals in crisis to mental health support – NYC 988 and B-HEARD – but the City has failed to scale these programs up adequately to meet the need.

The Behavioral Health Emergency Assistance Response Division (B-HEARD) was designed to take a health-centered response to 911 mental health calls, in place of a police-response. Where 911 operators assess a potential imminent threat of violence, a traditional emergency response is dispatched, which is comprised of NYPD officers and an ambulance.

B-HEARD teams are comprised of FDNY EMTs/paramedics, and mental health professionals from NYC Health + Hospitals. The program currently operates 7 days a week, 16 hours a day in certain parts of Manhattan, the Bronx, South Brooklyn and Western Queens, covering a total of 31 of 78 police precincts, or about 40%, including subway stations. B-HEARD teams do not respond to any emergency situations involving a weapon or imminent risk of harm to self or others.

Despite efforts to expand and reform the program, B-HEARD conducted mental health assessments in response to less than 1% of the mental health calls received in the pilot area during Fiscal Year 2024.[68] Sixty percent, or over 30,000 mental health calls were deemed ineligible for B-HEARD and received a police response with no mental health professionals present whatsoever.[69] While 20,451 calls were deemed eligible for a B-HEARD response, just 14,591 calls were responded to by B-HEARD team.

Figure 1: FY 2024 B-HEARD Response to Mental Health Calls



Source: Mayor's Office of Community Mental Health

B-HEARD has struggled to attract and retain qualified social workers, which has constrained the program's reach and efficacy.[70] The program has also been criticized for its failure to meet transparency and public reporting requirements or incorporate best practices for mental health response, such as the provision of trauma-informed care, culturally and linguistically competent service provision, or the integration of peers on teams and in leadership. The City has also failed to set goals for the program around key outcomes related to housing, justice-involvement, and long-term mental health stability.

The CAHOOTS program in Eugene, Oregon, demonstrates a more effective approach to crisis intervention. Operating 24/7 for over 30 years, CAHOOTS provides a citywide response to mental health crises, unlike B-HEARD, which operates only in limited areas of New York City and for just 16 hours a day. CAHOOTS handles approximately 100% of 911 calls related to mental health, with

police joining the response team in less than 1% of cases.[71] CAHOOTS focuses heavily on serving vulnerable populations, with approximately 60% of its calls involving unhoused individuals and 30% addressing serious mental illnesses.[72] Unlike B-HEARD, CAHOOTS is the default response, deploying civilian crisis workers, such as mental health practitioners and EMTs in every case, and limiting a police co-response to situations that involve a weapon or imminent threat.[73] This approach significantly increases the likelihood that individuals will be connected with mental health services and reduces the likelihood of law enforcement escalation during mental health crises, saving the local government an average of $8.5 million each year.[74]

Studies have found that programs like CAHOOTS result in reductions in arrests and improved mental health outcomes for those they serve.[75] By comparison, B-HEARD's limited reach, declining response rates, underfunding, and reliance on police highlight areas where New York City's program falls short. Mental health professionals and advocates have increasingly pointed to CAHOOTS as the best practice and model that should be replicated in New York City.

The City's CoC is sidelined and incomplete.

While the term continuum of care is frequently used in healthcare to describe a practice of providing coordinated, comprehensive treatment to patients over time, it is also a federally defined framework by which local governments must coordinate homeless services to qualify for certain forms of funding. HUD created the CoC process in 1994 to "provide a leadership role in local planning and coordination to prevent and eradicate homelessness."[76] The CoC duties in New York City include, but are not limited to:

- Streamlining and improving the assessment, prioritization, housing matching, and placement system for homeless and at-risk households through a coordinated, community-informed process.
- Reviewing and monitoring project and system performance to improve effectiveness, identifying and filling gaps of service, and informing strategic decision making for the CoC.
- Finding the gaps in the system for persons experiencing homelessness and focusing resources and/or implementing policies to address these gaps in New York City.
- Ensuring that policies are Housing First, fair, equitable, and free of bias.

The money available through HUD's CoC programs is the primary source of funding for nearly every other locality in the United States. In contrast, in a typical year, more than half of the City's spending on homelessness and shelter is covered through City dollars. In FY 24, New York City was eligible to apply for $200 million in CoC dollars, a fraction of the City's multi-billion-dollar DHS budget.

The City's outsized spending on homelessness and shelter is due in large part to New York City's legal right to shelter,[f] a crucial right that was established in 1981, nearly 15 years prior to the creation of the CoC.[77] [78] The Right to Shelter significantly expanded the rights and protections of homeless New Yorkers and has contained the City's unsheltered homeless population over time, especially as compared to cities like Los Angeles where the unsheltered homeless population was 29,275 in 2024.[79] However, the mandate to provide shelter and the struggle to live up to the policy standards set forth in the decree and subsequent legal challenges has oriented the focus on New York City's homelessness policies towards the creation and management of a vast network of shelters.

Table 1: Department of Homeless Services Funding Sources

Funding Source ($000s)	2024 Actual	FY 2025 - November Plan
City Funds	$2,175,852	$2,029,429
State	$1,087,704	$913,352
Federal - Other	$565,846	$566,825
Federal - CD	$718	$553
Other Categorical	$3,000	$3,000
Intra-City Other	$8,598	$7,096
TOTAL	**$3,841,718**	**$3,520,255**

Source: Office of Management & Budget

The CoC has made significant progress in creating the Coordinated Assessment and Placement System (CAPs) and in elevating the voices of people who have experienced homelessness. However, with a small amount of funding in the balance, the CoC is largely deprioritized by City leadership. The lack of power that the CoC has within DHS has ensured that Housing First policies have not been seriously considered or prioritized, despite the principle being a guiding mandate.

[f] In 1979, attorneys filed *Callahan v Carey,* a class action suit on behalf of all homeless men in New York. The landmark victory, achieved through a consent decree in 1981, established a legal right to shelter for New York City's homeless men and paved the way for similar rights for women, children, and families.

Table 2: Department of Homeless Services Budget by Program Area

($000s)	FY 22 Actual	FY 23 Actual	FY 24 Adopted	Preliminary Plan FY 24	Preliminary Plan FY 25	*Difference FY25-FY24
Adult Shelter Administration & Support	$11,431	$9,951	$7,753	$11,595	$7,824	$71
Adult Shelter Intake and Placement	15,505	12,523	12,577	13,176	13,319	742
Adult Shelter Operations	881,830	1,106,832	798,527	839,796	794,291	-4,236
Family Shelter Administration & Support	6,601	6,073	13,890	13,364	14,003	112
Family Shelter Intake and Placement	35,715	36,053	37,210	37,493	37,431	222
Family Shelter Operations	945,191	1,095,224	1,072,251	1,099,153	1,047,057	-25,194
General Administration	623,190	958,338	1,861,962	1,439,937	1,753,828	-108,134
Outreach, Drop-in and Reception Services	204,592	310,637	303,560	322,385	295,912	-7,648
Prevention and Aftercare	-4	0	0	0	0	0
Rental Assistance and Housing Placement	8,716	4,746	0	8,000	0	0
Total	**$2,732,767**	**$3,540,377**	**$4,107,730**	**$3,784,899**	**$3,963,665**	**($144,065)**

Source: City Council Analysis of Office & Management & Budget Data, March 2024

In addition to being sidelined by agency and City leadership, there are key stakeholders that are not required to participate in the CoC, limiting its effectiveness. General membership of the NYC CoC is open to all stakeholders interested in its purposes, but the Steering Committee, which is the primary decision-making body of the CoC, fails to include any representatives from the City's criminal justice or public health system. There is generally no participation from the State Office of Mental Health, DOHMH, and NYC Health + Hospitals, the Department of Correction, or the NYPD in the CoC at any level. While nonprofit leaders on the CoC have familiarity with these agencies' programs and policies, a lack of direct representation from State and City officials hinders the CoC's ability to develop and implement recommendations that would improve coordination.

Significant barriers keep people from accessing mental healthcare.

The most effective way for someone to receive psychiatric care is for them to seek it voluntarily. Studies have found much higher rates of readmission and less positive outcomes for patients who received care involuntarily, but obtaining affordable voluntary mental health care in New York City is a significant challenge due to Medicaid rate cuts and underinvestment in the City's mental health and human services workforce.[80]

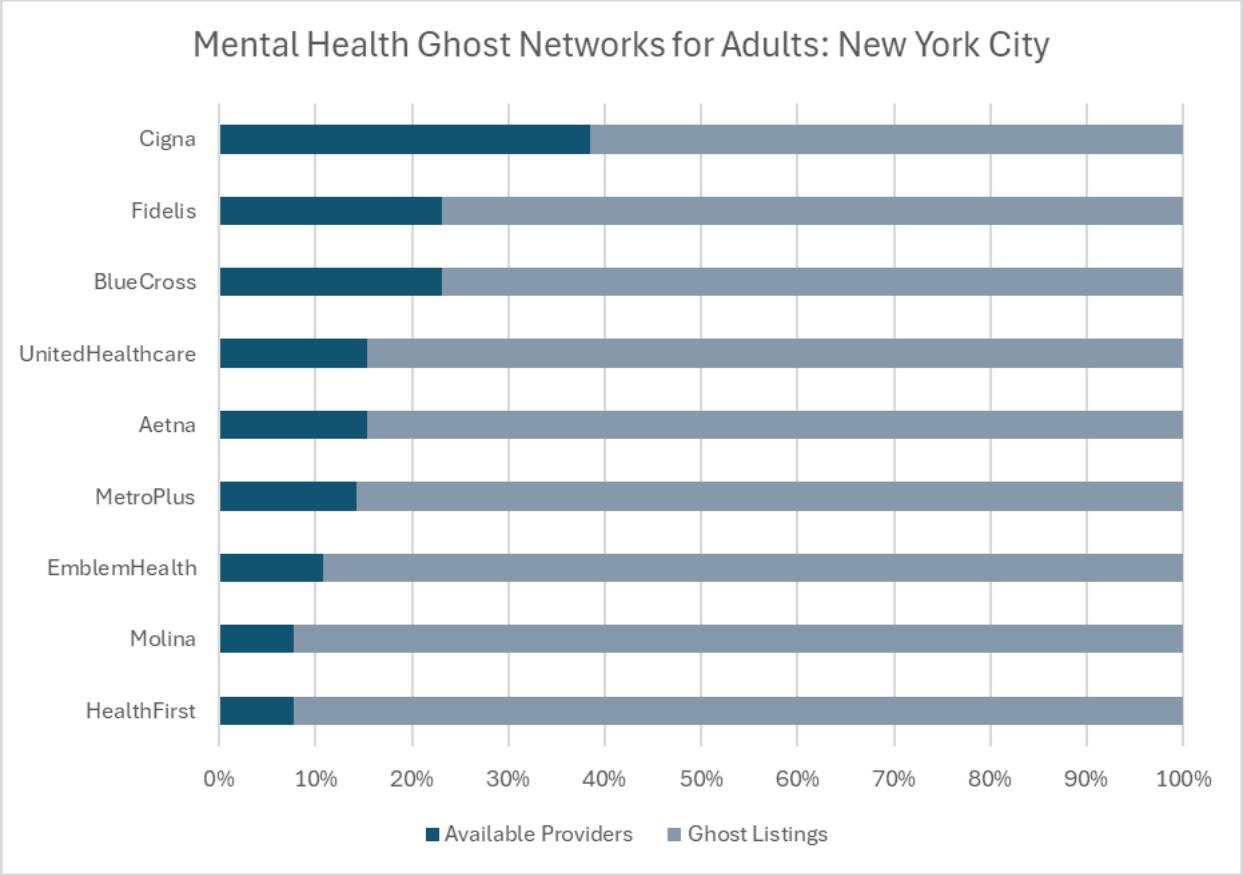
Vulnerable New Yorkers face significant barriers to accessing affordable culturally competent mental health care.

Today, there are significant barriers that prevent New Yorkers from accessing mental health care. These barriers create a troubling paradox in which people in acute crisis can more easily access services than someone voluntarily seeking therapeutic treatment or support in a time in which their symptoms are more manageable and easier to treat. Overcoming these barriers is critical to ensuring individuals with mental health needs receive the treatment they need *before* they reach a crisis point.

A recent study conducted by the City of New York found that in 2023, 945,000 adult New Yorkers or about 14% of the total population reported an unmet need for mental health treatment in the past 12 months.[81] Among adults surveyed who had experienced serious psychological distress in the last year, 46% cited cost as a factor for why they were not able to receive treatment and 43% said that they did not know where to go to get help.[82]

A 2023 investigation by the Office of the New York State Attorney General revealed that 86% of in-network mental health providers listed by insurance plans were either unreachable, not accepting new patients, or incorrectly listed in directories. This pervasive issue commonly referred to as "ghost networks" disproportionately harms those who rely on publicly funded insurance, which is the least likely to be accepted by providers due to lower reimbursement rates.[83]

Figure 2: Mental Health Ghost Networks for Adults: New York City



Source: Office of the New York State Attorney General

An additional study found that across New York State, outpatient office visits for mental health were 10 times more likely to be with an out of network provider than a primary care visit.[84] New Yorkers utilizing higher rates of out-of-network providers means they are paying much more out of pocket to access behavioral health services.[85] The out of network cost of psychotherapy in New York City is typically over $100 per session, with even higher rates for behavioral health providers who can prescribe medication or provide medication management. A RAND study also found that financial constraints were the most significant barrier to care, particularly for those without insurance coverage.[86]

The COVID-19 pandemic strained the system further, increasing demand for mental health care while creating new challenges in provider recruitment and retention. While telehealth expanded during this time, its effectiveness for individuals with SMI has been mixed, with patients raising concerns about quality of care, internet access issues, and providers appearing distracted or disengaged. Transportation barriers and a lack of culturally and linguistically appropriate services also presents challenges, especially for non-English speaking and low-income populations. While the City has increased translation services for individuals seeking treatment within the City's public health system, much more is still needed.[87]

And while significant progress has been made to advance modern mental health treatment protocols beyond harmful histories, a lack of trust towards practitioners, institutions, and treatment persists for many individuals. A 2022 Pew Research Center report revealed that 55% of Black Americans have experienced negative interactions with healthcare providers, including having their pain dismissed or needing to advocate for adequate care.[88] Similarly, findings from the National Institute on Minority Health and Health Disparities (NIMHD) show that racial discrimination from healthcare providers undermines trust and communication between Black patients and clinicians, exacerbating health inequities as people are less likely to seek care.

The City of New York has developed several programs, including a network of community-based healthcare providers and mobile treatment programs including ACT, FACT, SPACT, and IMT (See Appendix A) to address the challenges that high-need and low-income individuals face in finding affordable mental healthcare, but wait lists are long and capacity is limited given insufficient investment in these programs.[89]

Providers have indicated that the all-or-nothing approach to treatment plans exacerbates wait times, as participants remain in programs with a very high level of service for years because it is the only way they can access essential mental health services, such as injectable antipsychotic medication. If providers had the ability to taper services to clients over time while keeping them on their client list, they could increase their capacity without significant additional financial cost to the City or State. In fact, it could very likely reduce City and State costs over time. Additionally, clients feel a sense of accomplishment when they are able to graduate to this level of care and healthcare workers, for whom successes are often hard fought and far between, have their morale boosted. Finally, managing long-term mental illness is not linear, retaining contact with case workers and medical support, allows an individual to build a long-term relationship with their healthcare team and increase services as needed as symptoms fluctuate.

Private hospitals have reduced inpatient services and public hospital emergency rooms are overwhelmed due in large part to Medicaid rate cuts.

Emergency departments are often the only point of entry for those in an acute mental health crisis, but homeless individuals are frequently quickly discharged and return to the street without receiving comprehensive care, leaving people vulnerable to repeated crises. Care providers and lawyers report that private hospitals often discharge homeless individuals prematurely, sometimes under the assumption that they are feigning symptoms to secure a place to sleep. This process is often referred to as streeting and happens in part because the mandate to stabilize patients is difficult to fulfill, with a shortage of medical professionals and challenges in accessing medical records.

Additionally, psychiatric care often comes with low reimbursements from Medicaid, which is heavily utilized by individuals with low to no income, including people experiencing homelessness with SMI. This is driven in part by the Medicaid rate cut implemented by former Governor Cuomo, which limited reimbursement rates and revenues for the provision of health care to individuals

on Medicaid, in particular reducing payments for longer stays. Private hospitals may be reluctant to admit Medicaid patients, despite federal laws requiring stabilization of all individuals presenting with psychiatric needs.[g]

According to a 2023 *New York Times* investigation, the City's public hospitals, which treat nearly 50,000 psychiatric patients annually, are inundated with cases while private hospitals have systematically reduced their psychiatric services, cutting inpatient psychiatric beds to prioritize higher-revenue areas of care.[90] A 2020 report from the New York State Nurses Association cited by the *New York Times*, reported that hospitals earned $88,000 in net patient revenue per psychiatric bed in 2018, compared to $1.6 million per bed for all other types of care.[91] The de-prioritization of psychiatric beds accelerated during the COVID-19 pandemic, as many private hospitals closed psychiatric units to make room for COVID-19 care, with some units never reopening. By 2018, New York had only 16.3 psychiatric beds per 100,000 people, far below the recommended minimum of 50 beds per 100,000.[92] This shortage can lead to early discharges of individuals with mental health needs to free up hospital capacity, often worsening their conditions.

Over the last few years, Governor Hochul has taken several steps to address this crisis. In January 2023 as part of the State of the State address, Governor Kathy Hochul unveiled a sweeping multi-year $1 billion transformation plan to increase capacity for inpatient psychiatric treatment by 1,000 beds and added 3,500 housing units for individuals with mental illness.[93] The plan sought to increase access, reduce wait times and ensure appropriate levels of mental health care statewide. To date, 700 additional psychiatric inpatient beds, including 50 transition to home beds, have been brought online statewide through this initiative.[94] Medicaid rates remain well below the cost of care.

A shortage of health care professionals and undervaluing of contracted human service workers undermine the efficacy of City programs.

New York City's ability to provide adequate mental health care and stable housing to people experiencing street homelessness with serious mental illness rests in large part on the City's human services sector, which faces significant workforce challenges. Low wages drive workforce burnout and turnover, which further increases caseloads and wait times for clients. According to the Health Professional Shortage Area (HPSA), which is a designation used to identify areas that are experiencing a shortage of mental health professionals, the percent of need for mental health professionals met in New York State is 18.8%, compared to the national percentage of need met of 27.7%.[95] A December 2023 survey of National Association of Social Workers NYS Chapter (NASW-NYS) found that the average wait time for a new behavioral and mental health client was 2-4 weeks.[96]

[g] The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires hospitals to provide stabilizing treatment to anyone with an emergency medical condition (EMC).

The issue is both in retention and recruitment into the mental health industry, which is expensive to enter and offers low financial incentives. Prospective clinicians face significant costs, including licensure fees, education expenses (most requiring advanced degrees), and continuing education requirements. Low salaries further exacerbate these challenges, driving many clinicians out of the mental health field or into higher-paying roles within the private sector, leaving the public mental health system stretched dangerously thin. [97]

City-contracted human service workers, which includes social workers and mental health professionals, are also under strain. The vast majority of human service workers are women and people of color who generally make 71% of what government employees make and 82% of what private sector workers receive for the same role, which makes retention and recruitment extremely challenging.[98] The Supportive Housing Network of New York (SHNNY) cited suppressed wages as a particular source of instability for supportive housing employees, their families, and the communities they serve, citing a 20% vacancy rate in supportive housing positions in 2021. [99] While government workers are regularly provided with wage rate increases through a negotiated union structure, City-contracted nonprofits are rarely if ever provided the contract increases needed to ensure workers are paid living wages. This significantly constrains the effectiveness of the City's supportive housing, mental health, and outreach programs which struggle to recruit and retain staff in the face of compressed wages and large caseloads.

In the June 2023 Adopted Budget for Fiscal Year 2024, the City provided all human service nonprofits with a "Workforce Enhancement Initiative" rather than a cost of living adjustment (COLA) which produced far lower wage increases than were provided to government workers.[100] In response to advocacy, the Mayor announced a 3-year COLA for 80,000 city-contracted human service workers the following year in March 2024, which will invest $1.4 billion towards wage enhancements, the first of which took effect in July 2024.[101] The most recent COLA for human service workers represents a step forward to address workforce challenges constraining the City's capacity to tackle street homelessness for people with serious mental illness. However, the City's living wage laws remain woefully out of date and lower than New York State's minimum wage, without an automatic or required mechanism for increases wages over time.

Mandated mental health treatment can be difficult to effectuate and is constrained by a lack of appropriate residential facilities.

While voluntary mental health care is the most effective form of care, court-ordered programs such as AOT and diversion programs through mental health courts play a critical role in ending the revolving door of street homelessness, hospitalization, and detention for a small subset of people with serious mental illness. However, court-ordered and involuntary treatment can be difficult to secure and is constrained by a lack of appropriate residential facilities that provide adequate levels of mental health care, supervision, and security. For those who end up in City

jails, the City fails to provide adequate mental health care, leading to further deterioration and worsening mental health outcomes.

Involuntary treatment and hospitalization can be difficult to secure.

Much of the policy debate on the issue of street homelessness for people with serious mental illness has focused on involuntary hospitalization and the standards that should be used to mandate treatment when individuals are in crisis. The rules around involuntarily hospitalization are governed by the New York State Mental Hygiene Law (See Appendix B). They were designed to cover individuals in crisis, and to address the revolving door of patients who would stabilize in a hospital, only to decompensate after discharge due to a failure to comply with treatment plans. They aim to balance public safety and civil rights, mindful of both the grave risks of random violence and the grave historic harms of involuntary institutionalization.

The Mental Hygiene Law (MHL) authorizes a police officer or designated clinician to remove an individual into custody for a psychiatric evaluation, either to a CPEP or to an emergency room. If a person is brought to an emergency room, a physician must determine if the person meets the emergency standard prior to admission. If the patient is found to have a mental illness for which immediate observation, care and treatment in a hospital is appropriate, and which is likely to result in serious harm to themselves or others, they can be held for 48 hours, during which time a staff psychiatrist must confirm that the individual meets the emergency standard, and after which they can be admitted into a psychiatric inpatient facility for up to 15 days. Involuntary treatment for 60 days requires certification from two physicians. For involuntary retention beyond the initial 60-day period, the hospital must petition the court, demonstrating that the individual poses a substantial threat of harm to themselves or others. If approved, retention can extend for up to six months, with regular judicial reviews. Individuals in this category are entitled to legal representation and may request hearings to challenge their retention. [102] [103]

Kendra's Law, enacted on August 9, 1999, was created in response to the death of Kendra Webdale, a 32-year-old journalist from Buffalo who was fatally pushed in front of an oncoming New York City subway train by Andrew Goldstein, who had a decade-long history of mental illness and multiple short psychiatric hospitalizations.[104] The law established a statutory framework for Assisted Outpatient Treatment (AOT), a court-ordered, involuntary outpatient treatment program for individuals with serious mental illness.

In response to several tragic and high-profile violent incidents in recent years involving people with serious mental illness, City and State leaders have called attention to the barriers that can prevent involuntary treatment and hospitalization, especially for individuals living on the street. On February 18, 2022, the New York State Office of Mental Health (OMH) issued a memorandum entitled "Interpretive Guidance for the Involuntary and Custodial Transportation of Individuals for Emergency Assessments and for Emergency and Involuntary Inpatient Psychiatric Admissions," which functionally expanded the standard for removal of people experiencing serious mental illness to individuals who "appear" to be mentally ill. The guidance clarified that

individuals must display an "inability to meet basic living needs," but no recent dangerous act needs to have been observed.[105]

In the 2023 New York State budget, lawmakers extended and expanded Kendra's Law to allow officials to seek new AOT orders within six months of its expiration, without the previous criteria of violence. The law was also amended through the budget process to allow doctors to make virtual court appearances and required hospitals to share patient records with county health officers that supervise the AOT program to improve coordination.[106]

In November 2022, Mayor Adams issued an 11-point State Legislative Agenda, the Psychiatric Crisis Care Legislative Agenda, which took aim at "legal barriers to psychiatric crisis care and crisis avoidance" The proposal was comprised of two parts, barriers to hospitalization and care coordination, and barriers to AOT. Many of its priorities focused on improving access to psychiatric care through improved coordination across institutions in the mental health ecosystem, including hospitals and jails. One of Adams' proposals would amend the MHL itself to further expand the standard for involuntary hospitalization to include individuals whose mental illness prevents them from meeting their basic survival needs of food, clothing, shelter, or medical care, or those unable to recognize their urgent need for treatment, placing them at serious risk for deterioration.[107] Civil rights advocates and some community mental health providers have raised concerns that this proposal is overly broad and would violate constitutional due process protections.[108]

Other stakeholders, including mental health providers, outreach teams, and impacted populations have identified smaller gaps in the law that they believe could more effectively connect individuals in extreme circumstances to psychiatric care without curtailing individuals' civil liberties. The current law does not allow psychiatric nurse practitioners, who have specialized expertise in providing care to patients struggling with mental health problems in a clinical setting and are qualified to diagnose mental health disorders, to conduct evaluations. This significantly constrains the public hospital system's ability to conduct evaluations. Additionally, while practitioners who are conducting evaluations are permitted under the interpretation of the statute to consider prior medical history and reports from social workers, they are not *required* to consider that history, sometimes leaving significant gaps in assessments. Inadequate data and case file sharing systems often leave practitioners basing evaluations exclusively on the brief time during which the individual is under observation, rather than considering their full medical history, providing an incomplete picture of the person's ability to adhere to treatment plans. Addressing some of these targeted gaps in the law is the aim of the H.E.L.P. Act, sponsored by State Senator Brad Hoylman-Sigal and Assembly Member Micah Lasher.[109]

Mental Health Court diversion programs are effective in reducing recidivism, but program expansion is constrained by a lack of appropriate residential facilities.

Mental Health Courts are "problem solving" or community courts designed to divert individuals with SMI who have committed crimes away from incarceration into treatment programs.[110] The

courts aim to reduce recidivism by addressing the root causes of criminal behavior linked to mental health conditions.[111] In practice, the courts offer judicial supervision and connect participants to treatment services, often requiring 12-24 months of participation in a structured program, with the goal of reducing criminal charges upon successful completion.[112] The treatment program may include regular court check-ins, attendance at group therapy, drug testing, and medication compliance. At the completion of the program, the court may reduce or dismiss the individual's charges.[113]

There are mental health courts in operation in every borough of New York City, but because they require a high level of oversight, service provision, case management, and relationship development between judges and program participants, they are very small in scale, serving no more than 100 participants at one time. [114] [115] In addition to helping program participants grapple with mental illness, NYC's mental health courts also support participants to confront homelessness, unemployment, substance abuse, and serious health problems, working with a broad network of government and non-profit service providers to address these interrelated issues. Brooklyn's mental health court has served about 1,750 people since its inception in 2022, serving between 60 – 160 participants per year, reducing the likelihood of a rearrest for participants by 46%, with a 29% reduction in the likelihood of a reconviction for participants versus a comparison group. [116]

According to the Center for Justice Innovation, all of NYC's problem-solving courts are operating at or near capacity, but the expansion of mental health court programs hinges on the availability and quality of services that can be offered to program participants – including case workers, psychiatrists, and most notably the provision of stable, supportive, and/or secure housing.[117] If a case worker is unable to place an individual into a residential facility, judges are often hesitant to divert them into mental health court programs because it will be more difficult for the individual to comply with treatment programs if they are risk of living on the street.[118] This is especially true for individuals who are charged with violent crimes, as judges consider the public safety implications of diversion without placement in a secure residential facility.

Unfortunately, all of NYC's secure residential facilities, often referred to as "therapeutic communities" were designed specifically to treat substance use, not serious mental illness. There are currently no residential facilities for people who have serious mental illness but without an active substance abuse problem operating in New York City, making placements of individuals experiencing homeless with SMI a particular challenge.[119]

Even individuals facing non-violent misdemeanors referred into a mental health court may need to wait weeks or even months in jail to begin the program if there is no supportive housing available to them, undermining the program's goal of "timely" placement.[120] Manhattan's mental health court in particular has expressed eagerness to expand its capacity, but named the lack of residential facilities as a particular challenge. "Even if we can double capacity, we have to wait for a place to send them for their treatment," Judge Petitt-Cifarelli told the Daily News in 2023.[121] The lack of secure, semi-secure step-down facilities, and supportive housing for people with serious mental illness facing criminal and misdemeanor charges significantly limits options

for judges, leaving too many individuals with serious mental illness subjected to the horrific conditions of City jails without adequate psychiatric treatment.

The Department of Correction fails to connect people in detention to mental health care and outposted beds were delayed by the Adams administration.

Approximately 20% of detainees on Rikers Island have been diagnosed with a serious mental illness, while over 50% have some form of mental health diagnosis.[122] Many of these individuals endure lengthy periods of confinement and transfer between jails and state forensic psychiatric facilities, often for years, before standing trial.

The mental health services available in New York City jails are critically inadequate, leaving individuals with serious mental illness underserved and leading to worsening outcomes. In 2023, detainees on Rikers Island missed over 35,200 medical appointments, accounting for nearly 37% of all scheduled visits.[123] This systemic issue disproportionately affects those with mental health conditions, as missed appointments often result in exacerbated symptoms, increased risk of self-harm, and higher recidivism rates. A February 2024 report by the New York City Board of Correction revealed that several detainees who died in custody had missed numerous mental health appointments prior to their deaths; one individual missed 50 appointments in the four months before passing away.[124] People with mental illness stay in jail almost twice as long as everyone else.[125]

The Program to Accelerate Clinical Effectiveness (PACE) is a proven initiative aimed at delivering psychiatric care to individuals at Rikers Island, but there are just about 300 beds in a total of 10 PACE units in operation, leaving the vast majority of people with serious mental illness who may benefit from this level of care, at Rikers Island without adequate care.[126]

In 2019, Mayor Bill de Blasio announced a plan to create 250 outposted therapeutic beds for individuals in detention by DOC who require hospitalization.[127] In November 2021, the de Blasio Administration announced plans to expand the initiative to 360 beds, including an additional 120 beds at NYC Health + Hospitals/North Central Bronx and NYC Health + Hospitals/Woodhull.[128] These beds would be secure facilities, managed through a collaboration between Correctional Health Services (CHS, a part of H+H) and the DOC. CHS will oversee admissions and discharges based on clinical evaluations, ensuring that individuals with significant health needs receive proper treatment. The DOC will provide necessary security measures to maintain the safety of the units, allowing healthcare professionals to focus on delivering specialized care. These outposted therapeutic beds were designed to improve outcomes for incarcerated individuals with serious medical and mental health needs and would also aid in the City's efforts to close Rikers Island. Initial funding was secured by the de Blasio Administration in 2020.

Unfortunately, more than five years since the initiative was announced, none of the 360 beds are yet online. The Adams Administration delayed construction at the three initially designated H+H sites, which had been expected to start in 2021.[129] Administrative hurdles, shifting priorities, the involvement of multiple City and State agencies, and a lack of urgency have all contributed to the

delays. Construction of 104 beds at NYC H+H/Bellevue was underway as of March 2024, with completion expected by spring 2025, approximately six years after the initial announcement. Construction of 150 beds at NYC H+H/Woodhull is slated to begin in early 2025, with anticipated completion by late 2027.[130] The remaining 100 beds at NYC Health + Hospitals/North Central Bronx are projected to be completed by summer 2027.[131]

The planned capacity is also far from sufficient to meet the demand. These beds are intended to serve not just individuals with SMI, but the people on Rikers with serious medical needs. According to DOC data on any given day, there are approximately 1,400 people on Rikers and other City jails with serious mental health needs. The Independent Rikers Commission, chaired by former Chief Judge Jonathan Lippman, estimate that a total of at least 1,500 therapeutic beds are required to adequately serve individuals in DOC custody with complex medical and mental health needs.[132]

Lack of access to stable housing with support services leaves people with SMI cycling through crises.

Ultimately, for a person with serious mental illness to successfully stay off the street, they need stable housing with wraparound support and mental health services. Much public attention to the issue has focused on involuntary hospitalization and secure detention, which may be needed in certain cases of crisis, but without adequate pathways to stable housing, many people will return to the street from the hospital or jail, where their condition will likely worsen. New York's current systems substantially fail to connect people with serious mental illness to stable housing with services, whether they are on the street or subway, detained in jail, or receiving treatment in a hospital or other healthcare setting.

Homeless encampment sweeps fail to connect people to housing, so most remain on the street.

In March 2022, Mayor Eric Adams created a task force involving four City agencies: the DHS, the NYPD, the Department of Sanitation (DSNY) and the Department of Parks and Recreation (NYC Parks) to dismantle and remove homeless encampments across the city, in actions referred to as "cleanups" or "sweeps." Sweeps of homeless encampments had been a regular part of the street outreach policies under the de Blasio administration, although they were conducted with far less publicity as during the first six months of the Adams administration. The New York Times recently reported that the Adams administration has been responsible for 10,000 sweeps since taking office.[133]

A June 2023 audit by the Comptroller's Office examined the encampment sweeps conducted between March 21, 2022, and November 30, 2022. The audit revealed that the DHS outreach teams forcibly removed 2,308 individuals during these sweeps. The positive outcomes of these

efforts were minimal, with the audit finding that only 90 people (3.9%) stayed in shelter for more than a single day. As of January 23, 2023, only 47 people (2%) remained in shelter and only 3 people (0.1%) secured permanent housing. The vast majority likely simply moved to another outdoor location for the night.

The sweeps also largely failed to achieve their goal of eliminating encampments. On April 12, 2023, the Comptroller's auditors visited 99 identified locations where the task force swept in 2022 and found that people rebuilt some form of encampment at 31 sites. DHS did not adequately track placement referrals, nor did DHS document the support services it provided to people living in encampments who did not accept shelter placement. DHS also did not track any outcomes for people who did not accept shelter placement.[134]

In addition, interviews with key stakeholders and lawsuits filed against the City indicate that the personal belongings of homeless individuals are often discarded through these sweeps, including medication and identification documents.[135] Supportive housing programs require identification as a condition of eligibility, creating a paradox in which the City makes it harder for otherwise qualified candidates to be placed into supportive housing, despite that being the publicly stated goal. Finally, these sweeps make it more difficult for outreach workers to maintain contact with people living on the street, as those individuals become much more likely to move frequently to avoid negative interactions.[136]

Mobile treatment programs, hospitals, and jails all fail to connect people to stable housing despite established metrics and discharge planning requirements.

Homelessness persists for participants in mobile treatment programs.

The City and State have a number of programs to provide mobile treatment to people with SMI who are experiencing homelessness, including ACT, FACT, SPACT, and IMT (See Appendix A). All of these programs have a stated objective of helping individuals secure and stay in permanent housing options.

As of December 9, 2024, the last date for which data is available, 17% (or 1,179 individuals) of people currently enrolled in ACT experienced homelessness within the last six months.[137] While there is evidence that the housing specialists within ACT teams are successful in matching clients to permanent housing options, there is still a persistence of homelessness despite involvement in the program and the best efforts of staff, with 10% of individuals having experienced homelessness in the past six months even after three years in the program.[138] These individuals may have never found housing, they may have found housing and lost it or become homeless for the first time at some point after their enrollment. The data does not allow us to better understand the patterns but illustrates the challenge that many individuals within this population have in maintaining stable housing over time.

Additionally, the Office of the Comptroller's audit of IMT found that the percentage of clients who were able to acquire housing decreased from 47% to 30% over a 27-month period, and the percentage of clients who were able to retain stable housing dropped from 44% to 37% over a 21-month period. [139] DOHMH attributed these declines to an increase in the number of clients who need housing along with a shortage of available and affordable housing.

Although an individual's enrollment in one of these treatment programs may increase their chances of being matched to supportive housing as it likely increases their score on the standardized vulnerability assessment tool, IMT, ACT, or AOT have no dedicated vouchers or resources for housing placements beyond having a housing specialist on staff to help match people to units.

Hospitals, emergency rooms, and CPEPs do not adequately connect individuals to housing at discharge.

Guidance from the New York State Office of Mental Health indicates that when medical professionals are discharging a patient from a CPEP, Emergency Department, or inpatient treatment program the individual should be screened for complex needs that would affect their ability to transition to community-based care. Complex needs are defined as someone who has a high utilization of acute care services, extensive adverse childhood or trauma histories or a high level of social determinants of health that could negatively impact their ability to integrate back into the community.[140]

The guidance instructs medical providers to work collaboratively with case managers, even if they are not employees affiliated with the healthcare institution, who can help ensure that the individual being discharged is connected to outpatient treatment, care coordination, and residential resources. It further instructs providers within a CPEP or Emergency Room to consider the individual's ability to be safe in the community based on their ability to remain safely housed, their involvement with the criminal justice system and their potential exposure to violence as part of the discharge planning process. The guidance for discharge planning for inpatient treatment programs instructs providers to assess additional social determinants of health, including food insecurity, transportation and linguistic needs, family and community support, employment, education, immigration, and veteran status – with a particular focus on homelessness or insecure housing. [141]

The guidance makes clear that these indicators will have a large impact on the success or failure of any discharge plan and should be strongly considered. However, it does not provide any additional instruction other than suggesting that "[r]eferrals to social services agencies should be made as part of discharge planning if they are available in the community."[142]

There is no available data that illustrates how discharge planning from Emergency Rooms or CPEPs may intervene in a cycle of housing instability for individuals seeking care who are currently experiencing street homeless, but data available from Local Law 3 creates a high-level picture of the challenges that providers have in securing stable housing for patients during discharge planning from inpatient settings.

According to Local Law 3 data, in Fiscal Year 2024 1,406 people were found to be eligible for supportive housing while they were residing at a State Psychiatric Center, a Transitional Living Residence or Apartment Treatment Program, or a hospital setting. Only 344 of these individuals, or 25%, were accepted into supportive housing within the same fiscal year.[143] While some number of these individuals undoubtedly moved into the City's shelter system or found some other form of housing following discharge, it is likely that some people were discharged onto the street, or quickly found their way back there after a brief stay within the shelter system, reducing the efficacy of the treatment they received during their inpatient stay. Given the briefer period of interaction between a provider and a patient in the ER or a CPEP, the referral and acceptance rate into supportive housing following discharge is likely even lower, if the application for supportive housing is even filled out during their visit.[h]

In addition to the scarcity of supportive housing units overall, there is also not a wide enough range of housing or treatment options to meet the needs of street homeless New Yorkers with SMI. For example, some people need a step from leaving inpatient programs before returning to a more community integrated supportive housing setting, while someone else may need a level of treatment not provided by outpatient care but not as intensive as an inpatient program.

New York City Health + Hospitals has opened three Extended Care Units (ECUs) in the past several years that have served over 300 patients with serious mental illness who have been historically disconnected from health and social services. ECUs provide more intensive inpatient treatment, take a person-centered approach to care and include much more comprehensive discharge and aftercare planning. Admission to the ECU is voluntary and patients can stay up to 120 days, much longer than the traditional 21 day stay in a traditional inpatient program. Increasing programs such as this can ensure that healthcare workers have the time they need to match clients with appropriate housing after treatment.[144]

Given the significant barriers to care that exist within the public mental health care system and the deleterious impact of cycling through emergency rooms and treatment programs without long-term stabilization, it is unacceptable that vulnerable individuals be discharged from healthcare institutions without being matched with a stable, affordable place to live.

City jails routinely violate court mandated discharge requirements.

In 1999, the Urban Justice Center and New York Lawyers for the Public Interested filed *Brad H. v. City of New York,* a class action lawsuit challenging New York City's practice of "discharging people with mental health concerns from City jails in the middle of the night with only $1.50 and two tokens without any psychiatric medication or treatment referrals."[145] To have "BradH status"

[h] To be sure, data made available through Local Law 217 indicates that some people are first connected to HOME-STAT teams through a discharge planning process in a hospital setting, however, the data does not provide any information on how many of these individuals were eventually able to secure permanent housing or other forms of ongoing services. Local Law 3 data shows that 206 people were found eligible for supportive housing in a non-SPC hospital but it is unclear if they were found eligible during an inpatient stay or through a visit to an ER or CPEP.

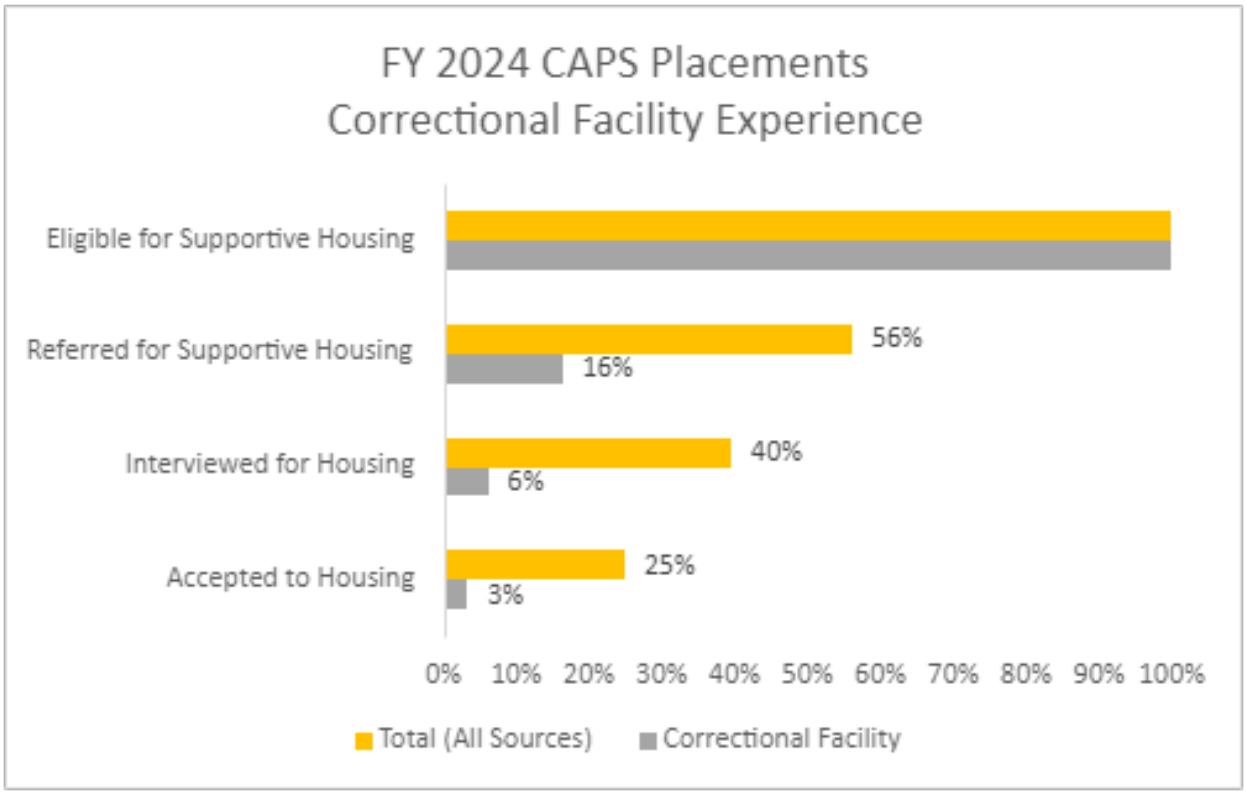
means that an incarcerated individual is eligible for discharge planning under the standards set by the *Brad H. v. City of New York* settlement.

BradH applies to any individual who received mental health treatment during their detention, not just individuals with an SMI diagnosis, covering a huge portion of individuals on Rikers Island. As of December 12, 2024, there were 3,796 individuals with BradH status.[146]

Compliance with these standards is critical, as it ensures individuals with serious mental illness leaving jail are connected to the care and services they need. BradH individuals are entitled to a treatment and discharge plan for their release, including a 7-day supply of medication, prescription lasting 21 days, and reinstated Medicaid or Medicare.[147] Under BradH, DOC is also legally required to submit a supportive housing application for the individuals with SMI. As noted previously, the portion of people detained on Rikers Island with serious mental illness has increased rapidly since the outset of the pandemic from just 14.92% in February of 2020 to 21.15% as of September 2024, or approximately 1,400 people.[148] The total population of people with SMI on Rikers has grown by 70% over that same period.[149] Failure to comply with BradH standards can lead to the breakdown of this continuity of care, resulting in preventable homelessness, hospitalization, or reincarceration.[150]

The City's discharge planning is subject to ongoing oversight by two court-appointed monitors. According to their most recent report, the City's CHS was found to be compliant with BradH for SMI assessments at 94%, 83.% compliant with HRA 2010e housing applications and 84.6% compliant with forwarding of supportive housing approvals. However, they were also found to be non-compliant for the provision of case management (55%) and especially for appropriateness of supportive housing (24%).[151] This non-compliance creates significant gaps in care and disrupts individuals' ability to connect to critical resources, and makes it far more likely they will end up sleeping on the street, to reoffend, and to continue to cycle through crises.

Figure 3: 2024 CAPS Placements – Correctional Facility Experience



Source: HRA Local Law 3 Data

A review of data produced under Local Law 3 of 2022 revealed that while 717 people discharged from City jails were eligible for supportive housing, just 24 individuals, or 3%, were successfully placed into supportive housing in Fiscal Year 2024. The Monitor's report also highlights that 13% of social work positions remained unfilled by permanent staff as the BradH population has continued to increase, flagging a serious capacity and workforce challenge.[152]

Supportive housing production continues to lag.

There are currently 40,472 units of supportive housing in New York City.[153] Compelled to action after years of community organizing, the New York/New York Agreements in 1990, 1999, and 2005 marked pivotal collaborations between the City and State to tackle homelessness and mental illness through increased public spending on supportive housing.

- NY/NY (1990) provided housing and services to 5,225 homeless persons with mental illness. Five hundred additional units were added to NY/NY I in 1993;
- NY/NY II (1999) added 2,320 units of housing that were rolled out 2004;
- NY/NY III (2005) added 9,000 units of housing; 7,500 of these units were for single adults, and 1,500 units were for families and were rolled out through 2016.

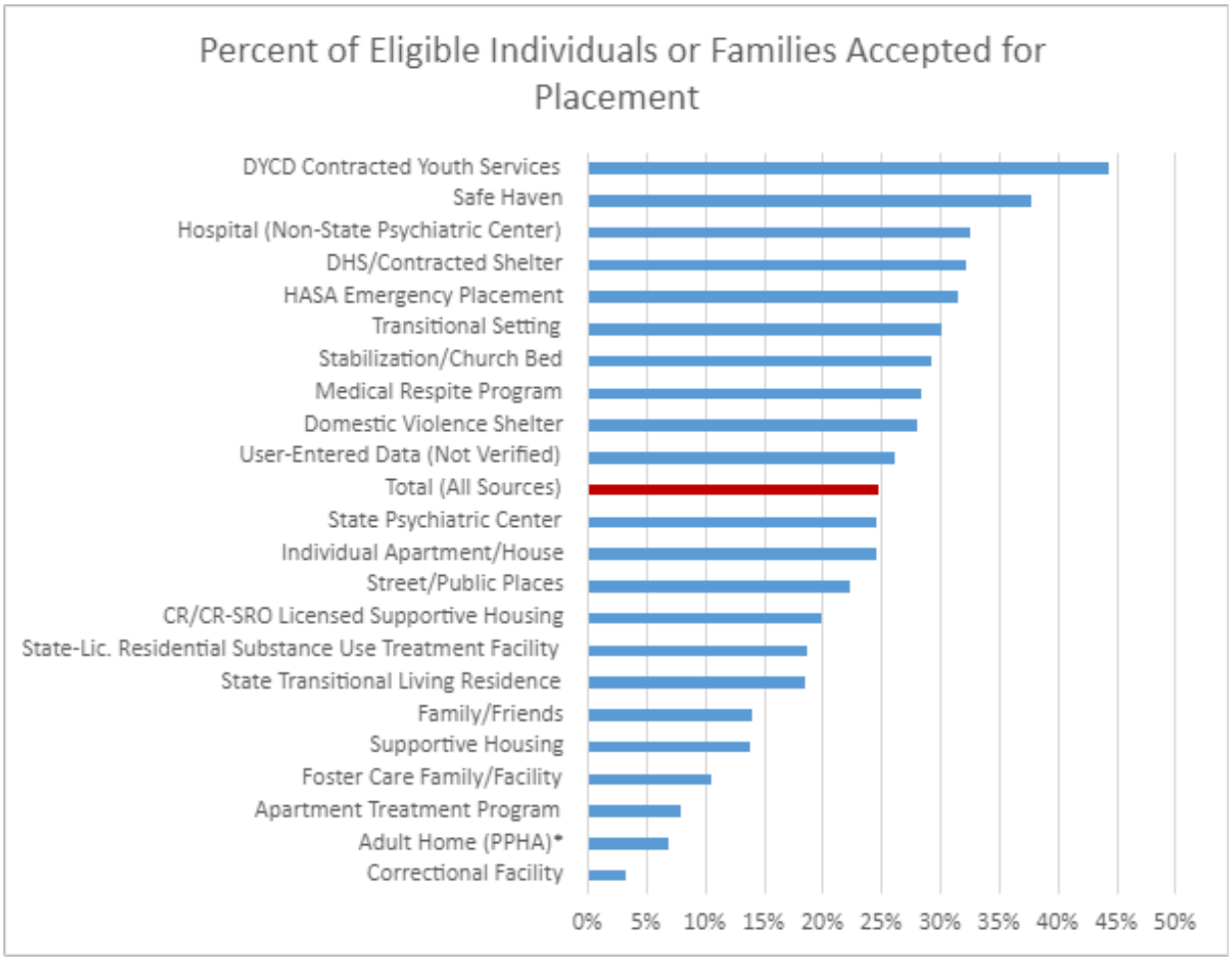
After former Governor Andrew Cuomo refused to work collaboratively with the City of New York to create a new NY/NY agreement, former Mayor de Blasio launched NYC 15/15 in 2015. NYC 15/15 is a commitment to create 15,000 total new units of supportive housing over 15 years; 7,500 congregate and 7,500 scattered site. One year later, former Governor Andrew Cuomo announced a plan to build 20,000 units of supportive housing across New York State through the Empire State Supportive Housing Initiative (ESSHI). But despite an increasing number of supportive housing starts, a report from the City Comptroller's Office found that the timeline to project completion increased from 3.1 years in FY 17 – FY 19 to 3.75 years in FY 21 – FY 23 for projects within the Special Needs Housing loan programs, which includes supportive housing due to management failures at HPD and City Hall. The NYC 15/15 initiative had delivered fewer than 4,000 of the promised 15,000 units as of May 2024 and there were only about 5,000 units online across New York State through ESSHI as of February 2024.[154] [155]

Figure 4: Supportive Housing Starts, Fiscal Years 2014 - 2024

Source: Department of Housing, Preservation & Development

Data available through Local Law 3 indicates that only a fraction of the people that are found to be eligible for supportive housing are able to secure a placement within the same fiscal year. Of the 9,678 people who were found to be eligible only 2,404 or 25% were accepted for placement in FY 2024.[156] Indicating that more supportive housing is needed overall to meet demand.

Figure 5: Percent of Eligible Individuals or Families Accepted for Placement



Source: HRA Local Law 3 Data

Providers double up CR-SRO units to meet surging demand, preventing people from being matched to appropriate units.

A Community Residence-Single Room Occupancy building (CR-SRO) is a form of supportive housing designed specifically for adults with serious mental illness. In New York City there are 2,116 units of CR-SROs dispersed throughout the five boroughs and 518 units that are run directly by the State in coordination with a SPC.[157] While traditional models of supportive housing typically have a staff to resident ratio of approximately 1 to 30, CR-SROs have a ratio of about 1 to 10 and provide a higher level of services. The provider must maintain 24-hour staffing, provide robust on-site services such as medication and case management, meal planning and cooking, and coaching and life skills.[158]

In order to increase capacity and in the face of structural funding deficits and unit shortages, some providers operate double rooms within CR-SROs, limiting resident privacy. Single rooms

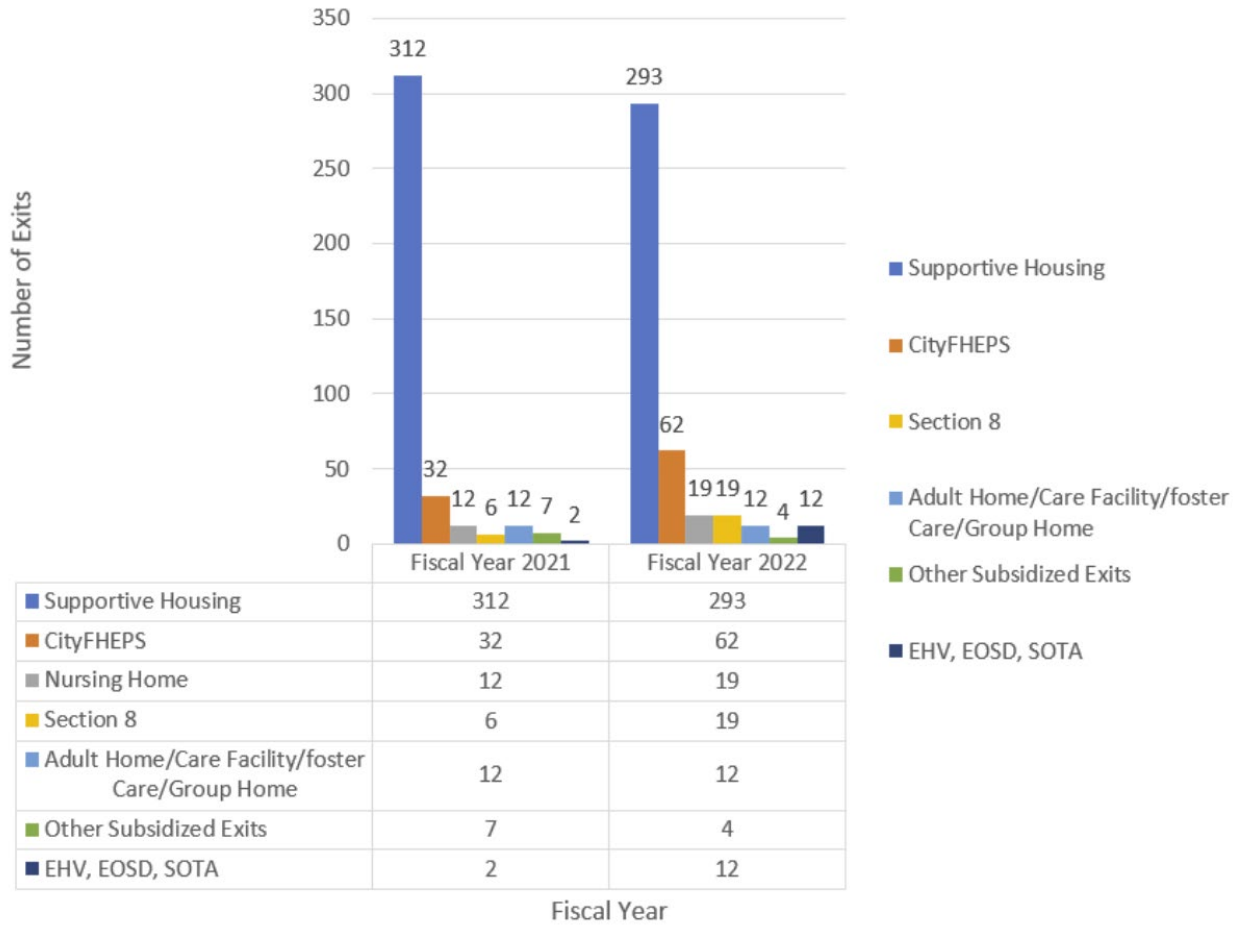
more directly address the barriers that often keep individuals experiencing street homelessness from coming indoors and are the best housing practice for people living with SMI.[159] Individuals who have higher service needs who are matched to these units often reject them because they want privacy that doubled up units do not provide, keeping them in shelter or on the street and trapped in a cycle of client or provider rejection from supportive housing. The City should work with service providers to ensure that this housing remains single room so that New Yorkers with higher needs are matched to housing with an appropriate level of services and barriers to acceptance are removed.

Vacancies persist in supportive housing, especially in older SRO units.

Outreach workers and staff at drop-in centers build relationships with individuals over time, with the hope that they will eventually accept a placement into a safe haven shelter or a stabilization bed. Individuals who have been living outdoors for at least nine months can access these beds, which don't require intake at a central processing center and are a less restrictive alternative to traditional shelters. Ideally, safe havens offer more privacy and provide intensive case management, mental health, and substance abuse assistance, although an increasing number of these shelters have been creating double or quad units. Stabilization beds have the same flexibility, but case management is provided through scheduled visits. They are reserved for clients who are on DHS's caseload and are determined to be able to care for themselves.

An audit by the Office of the New York City Comptroller found that the average length of stay in a safe haven bed was 400 days in both fiscal year 2021 and 2022, while the length of stay in stabilization beds was 242 and 307 days respectively. Only 28% of people exit safe haven or stabilization beds into subsidized housing – the majority, 68% exit on their own, many most likely returning to the street. Of those who exited these low barrier options with a housing subsidy in FY 21 and 22, 75% moved into supportive housing.[160] Once individuals access supportive housing, the vast majority remain stably housed – with studies finding that only 5% of tenants return to streets or shelters.[161]

Figure 6: Subsidized Exits from Low Barrier Beds – Fiscal Years 2021 & 2022



	Fiscal Year 2021	Fiscal Year 2022
Supportive Housing	312	293
CityFHEPS	32	62
Nursing Home	12	19
Section 8	6	19
Adult Home/Care Facility/foster Care/Group Home	12	12
Other Subsidized Exits	7	4
EHV, EOSD, SOTA	2	12

Source: Office of the Comptroller (Review of the New York City Department of Homeless Services' Programs and Services :Office of the New York City Comptroller Brad Lander)

Once a case worker completes an individual's supportive housing application, which includes a psychiatric evaluation and psychosocial assessment, and is found eligible for supportive housing, their case is entered in the CAPS. When an apartment becomes available for which they qualify and are interested, an appointment to tour the building and the apartment is set. Guidance from the DOHMH and HPD instructs supportive housing providers that they should not use this appointment to conduct a clinical assessment or to reestablish an individual's clinical eligibility for a unit, as that was already determined through the supportive housing application process.[162]

Local Law 3 provides demographic information on who is applying for and getting placed into the City's supportive housing. Interviews with many stakeholders, in addition to a review of the case notes, indicate that many people who are in the greatest need of supportive housing are rejected due to the severity of their disability.

HUD requires that all supportive housing projects implement low barrier admissions policies, defined as policies that "screen-in" rather than "screen out" applicants with the greatest barriers to housing. However, based on a review of several years of data made public through Local Law 3, it remains common for supportive housing applicants to be rejected because supportive housing staff believe that a client is not being forthcoming about their mental health or substance use,

The number of SRO units in New York City grew significantly between the 1920s and early 1950s. By the mid-twentieth century there were nearly 200,000 SRO units, or more than 10% of the city's rental stock. However, by the mid-1950s, elected officials, fueled by racism, xenophobia and white protestant ideals of living standards, passed policies that banned the creation of any new SROs, rather than investing in the housing or compelling owners to do so. Additional public policy over the next thirty years incentivized the conversion of existing SROs into apartment style units, fueling speculation, landlord disinvestment and the harassment and eviction of low-income tenants.

As early as the 1960s, the City's Department of Human Resources Administration (HRA), not for profit staff provided services to residents of the City's SROs, with some organizations placing full time staff at some of the buildings, and staff from the Community Psychiatry Division of St. Luke's Hospital made some of the first attempts to provide treatment to residents with serious mental illness where they lived. Pioneering organizations such as West Side Federation for Senior and Supportive Housing (WSHFSH), the Center for Urban Community Services, and Project FIND began cobbling together a patchwork of capital and operating subsidies from the City, State, and federal government to acquire, renovate dilapidated rooming houses and provide support services on site, creating the first model of supportive housing.

By the early 1980s, the City began providing capital dollars to finance the repairs of these buildings and several new advocacy organizations began organizing SRO residents. However, despite growing recognition that there was a direct connection between rising homelessness and the dwindling number of affordable SRO units, the City did not act quickly enough to reverse course. By 1995 there were fewer than 40,000 remaining SRO units in New York City.

or because the provider does not think that the program provides the level of care that they believe the client needs.

Once an individual has navigated the application gauntlet, many reject an SRO unit that requires someone to share a bathroom and typically do not have a kitchenette, as they prefer a newly constructed apartment with a separate bathroom, a kitchenette, and additional building amenities.[163]

Testimony from the Supportive Housing Network of New York (SHNNY), which represents dozens of supportive housing providers, in addition to local reporting, has found that since 2021 there have been between 1,400 and 2,500 vacant units of supportive housing. SHNNY testified on May 3, 2022, to the New York City Council Committee on General Welfare that based on a fall 2021 survey of their members, there were 2,500 units vacant, representing a 10% vacancy rate across all supportive housing in New York City.[164]

In April 2024, Council Member Lincoln Restler introduced Int. 791, which would create a real-time public dashboard to track vacancies, with information about the number of units and the reasons and the length of the vacancies.[165] A January 6, 2025, article from the City, indicated that as of September 3, 2024, 4,117 units of supportive housing run by dozens of not-for-profit providers were vacant. The length of vacancy varied widely, with some likely sitting vacant for only a few months and others vacant for several years. Of the 1,971 units that were identified as being "online" or as being ready for tenant to move into, more than 400 of them had been empty for more than a year. An additional 2,146 units would require some level of renovation before a tenant can move in, with over 700 of those units being vacant for more than one year.[166]

Interviews with key stakeholders indicated that many of those vacancies are units in SRO supportive housing for the reasons laid out above. SROs are an essential part of the history of supportive housing and remain a vital part of the solution to homelessness. Scaling up a housing first program for people with SMI experiencing street homelessness, with adequate support service resources provided, can address these vacancies.

The State does not do its fair share to comply with the Right to Shelter, fund supportive housing, or prevent homelessness.

New York State and New York City are equally obligated under the New York State Constitution and a Consent Decree to provide shelter to single adults and eligible families experiencing homelessness, but New York State has continuously failed to do its fair share. In FY 2024, New York State paid only 6% of the City's budget for emergency shelter for single adults and provided zero state funding to support stabilization or safe haven beds. Prior to state fiscal year 2012, New York State payments for single adult shelters were based on previous years' expenses, up to a cap, which averaged $82 million from 2007 to 2011. The City could also request up to $10 million annually for improved shelter conditions for medically frail adults. In 2012, the State removed language that tied funding to prior shelter costs and lowered the cap to $69 million, where it has remained – despite inflation and a rising shelter population. If the State had contributed 47

percent of the adult shelter budget in FY 2024, its share would have been $563 million, nearly half a billion more annually than it currently pays.[167]

Similarly, while long-standing supportive housing units under New York/New York I, II, and III have been either wholly funded or split funded with the State for decades, the NYC 15/15 initiative was funded solely by the City when Governor Cuomo failed to reach an agreement with the de Blasio administration. The City also increased funding for the New York/New York-funded supportive housing units to protect them from rental market pressures, but the State has not stepped up to increase its share which puts these existing units at risk.[168]

For several years, the sponsors of the HAVP legislation (S568B/A4021A) have requested an allocation of $250 million for the first year of the program. The legislation requires that at least 50% of the funds that would be allocated to New York City would be provided to individuals currently experiencing homelessness. Importantly the legislation makes explicit that the voucher be available regardless of immigration status.[169] Prior to the introduction of HAVP, the State failed to pass precursor legislation such as the Home Stability Support Act that attempted to address the inadequate shelter allowance through public assistance by providing a statewide rental supplement for New Yorkers who are facing eviction or homelessness, or a loss of housing due to domestic violence or hazardous housing conditions. Despite the fact that there is broad support for HAVP, from homelessness advocates, community groups, and the real estate industry – it has not been passed or funded.

Recommendations

The increasing visibility of individuals with serious mental illness on the streets and subways is not an inevitability, but a reflection of failed policies across City and State housing, healthcare, and criminal justice systems. Fragmented care, a lack of affordable housing, and inadequate mental health services have left many individuals cycling through emergency rooms, jails, and the streets.

Street homelessness worsens mental health issues, as individuals are continuously exposed to harmful social determinants of health (SDOH) such as lack of access to healthcare, food or safety and social exclusion and stress.[170] Research consistently shows that providing stable housing to individuals with serious mental illness significantly reduces costly emergency room visits, hospitalizations, and criminal justice system involvement – allowing people to stabilize their health and lives.[171]

With better coordination and management from City Hall and a diligent focus on outcomes, with more effective outreach in both non-crisis and crisis situations, with a "housing first" approach that includes robust support service that evidence suggests will work most of the time, and with more effective and secure detention options when it doesn't, New York City can dramatically reduce – and even effectively end – street homelessness of people with serious mental illness.

Improve City Hall management and coordination with a diligent focus on outcomes.

The City spends billions of dollars on programs designed to meet the needs of people with serious mental illness experiencing homeless – outreach, mobile treatment programs, emergency response, police, hospitals, shelters, and jails all play a critical role in solving street homelessness for people with serious mental illness. Despite renewed focus from City and State leaders in the wake of tragic and random acts of violence, people with serious mental illness experiencing street homelessness continuously fall through the cracks. The City desperately needs a strong management approach to ending this crisis, starting at City Hall. Through the development of key performance indicators, improved data sharing systems, and strong day-to-day coordination across the litany of programs in place designed to ensure this population receives adequate care, we can dramatically improve the quality of services and outcomes – and improve public safety along the way.

The City should immediately:

- Create a dedicated team at City Hall that drives resource deployment and decision-making citywide, with a focus on stabilizing and housing the highest risk populations living on the street. The team's first directive should be to map and publish the network of short- and long-term mental health services available to these populations both inside and outside the city's control, making note of deficiencies in the network that persist in failing to address the needs of the unhoused. That team should meet weekly

with the Mayor, agency commissioners, the City's CoC staff, and key service providers to review the status of individuals on the by-name list, including the city's "top 50" list of the most acutely at-risk individuals.[172]

- Set ambitious goals for ending street homelessness for people with serious mental illness, and rigorously track short, medium, and long-term key performance indicators that can be shared and updated seamlessly across non-profit and government stakeholders. This should include the immediate implementation of technology upgrades and data sharing agreements to integrate data systems across nonprofit, City and State providers while protecting people's privacy and complying with the Health Insurance Portability and Accountability Act (HIPAA).
- Regularly conduct program evaluations to identify gaps in services and hone successful models to drive program modifications and expansions. Provide technical and data analytic support to key stakeholders in the development and execution of program evaluation models.

Empower and expand the City's CoC to facilitate program implementation and improve coordination.

With stronger leadership from City Hall, the City's CoC should be empowered to execute Mayoral priorities and improve coordination across the thousands of public servants and non-profit workers responsible for executing this plan. The CoC is already tasked by Federal statute with critical functions including reviewing and monitoring the City's Homeless Management Information System, identifying and filling gaps of service in the system for people experiencing homelessness, and ensuring that policies are Housing First. But the CoC is inadequately resourced and fails to integrate the City's criminal justice and health care systems. With expanded participation, enhanced staffing resources, and increased responsibilities, the City's CoC could be empowered to provide the day-to-day oversight needed to end street homelessness for people with serious mental illness.

The City's CoC should:

- Require participation from the DOC, the NYPD, New York State Courts, District Attorneys, and Defense Attorneys, the City's Health + Hospitals system, and the New York State Office of Mental Health, in addition to the City's nonprofit supportive housing and mental health service providers and individuals with lived experience of homelessness who already regularly participate in the CoC.
- Implement City Hall priorities, including resource allocation and deployment, budget modifications, issuance of requests for proposals, and the initiation of contract modifications to adjust and expand programs as needed, in consultation with providers.
- Facilitate coordination between the City's jails and hospitals with the City's housing, homelessness, and mental health services providers through regular meetings and data systems review to ensure all relevant stakeholders have the critical information they

need regarding clients' engagement across government and non-profit parties (including admission, discharge, and program participation).

- Determine how to best incorporate a Housing First model for street homeless individuals with SMI within the City's existing CAPS, including the creation of new policies that expand a Housing First and warm hand off model to individuals at risk or experiencing street homelessness with SMI being discharged from the City's healthcare institutions or jails.
- Regularly report to City Hall and agency leadership on the status of implementation, programmatic challenges, priorities, and recommendations for improvements.

Improve and expand proactive subway and neighborhood outreach teams.

Chronically homeless individuals living on the street have typically been failed repeatedly by previous interventions from government and social service providers. Building a personal relationship with an outreach worker is often needed prior to someone being willing to make a life-changing decision to come inside. Outreach workers consistently say that they are best able to connect with people living on the street when they can offer people what they want. Ensuring that existing and expanded outreach teams have the resources they need to build trust over time, such as socks, warm clothes, and care kits, in addition to being able to connect people with medical treatment without requiring transportation to a clinic or hospital is essential to the success of these programs.

To end street homelessness for people with serious mental illness, these promising outreach programs must be dramatically expanded. Expansion must come with a stronger management framework to set clear goals and increased coordination between programs with shared goals, increased data collection and publication of outcomes, and the reduction of bureaucratic barriers between City and State institutions. These improvements will allow the City and State to better track the individuals these teams are engaging across institutions and ensure continued access to psychiatric care. The City and State should immediately work together to:

- Expand promising outreach programs for people experiencing street homelessness with serious mental illness including new State programs such as SOS, SCOUT, and PATH to increase shifts, coverage areas, and response rates; ensure programs can hire and retain qualified staff; and increase providers' capacity for data collection and analysis.
- Ensure that outreach teams are provided with the resources they need to build long-term trust and create opportunities for continued engagement including socks, food, basic medical care, and blankets among other necessities.
- Set clear and consistent programmatic short- and long-term goals including treatment adherence rates and placements into permanent housing and impose quarterly and real-time reporting requirements.

- Improve StreetSmart to create a centralized real-time data platform that outreach providers can use across City and State outreach teams. Ensure integration with other platforms such as CARES to ensure that diversion strategies and client outcomes can be tracked over time.
- Work to integrate these systems into the State Office of Mental Health's data platform for behavioral health, PSYCKES, and ensure timely data reporting systems across institutions and nonprofits while protecting individuals' privacy to ensure mental health practitioners are notified immediately when an individual in their programs has an interaction with law enforcement or is admitted to or discharged from City or State funded jails, hospitals, and shelters.

Re-Envision the City's framework for mental health emergency response.

When a New Yorker calls 911 to report someone in need of mental health crisis support, they should feel confident that the person will receive help from mental health professionals and that police will be deployed responsibly to protect everyone's safety. Unfortunately, most mental health calls are responded to by police officers, who do not have the necessary skills to deescalate situations or connect individuals to adequate health care.

The City needs to fully re-envision its mental health emergency response framework to:

- Deploy mental health professionals and peer responders to 100% of 911 mental health crisis calls through a new citywide, 24-7 program modeled on CAHOOTS, incorporating best practices to mental health crisis response including trauma-informed care and culturally and linguistically appropriate services.
- Deploy police officers alongside those mental health professionals in cases where the 911 operators determine there is an imminent threat.
- Develop a strategic plan for transitioning operational responsibility for crisis response to the Department of Health and Mental Hygiene and address the potential need for a new dedicated title and unique competencies mental health professionals operating in a CAHOOTS model may require.
- Require all in-service officers who have not yet participated in CIT to complete the training, ensuring comprehensive coverage across the department and mandatory annual refresher courses for all officers to maintain and enhance their skills. These courses should be designed in partnership with DOHMH and include trauma-informed care, collaboration with mental health professionals, peer responders, mobile crisis teams, and cultural competency.
- Implement a standardized curriculum for all 911 call center operators to ensure operators can assess and triage mental health crisis calls effectively. Training should incorporate scenario-based exercises, cultural and linguistic competency, and trauma-

informed communication techniques. Operators must also have access to on-call mental health professionals to provide real-time consultation and decision-making support.

- Increase public transparency and rigorously track outcomes through the creation of a centralized database for all mental health crisis responses. The database should detail who responded (e.g., mental health professionals, peer responders, police, mobile crisis teams, etc.), the nature of the intervention, and both immediate and long-term outcomes. Key metrics must include hospitalization rates, repeat crisis calls, and connections to ongoing care, disaggregated by demographics to identify disparities. Monthly reports on these outcomes should be made publicly available to ensure transparency, promote accountability, and guide data-driven improvements to crisis response strategies. This data tracking initiative should be integrated with existing mental health data systems to provide a more comprehensive view of citywide progress in addressing mental health crises.
- Create an independent oversight team to monitor and evaluate the mental health crisis response system. This team should review response times, adherence to trauma-informed and culturally competent care standards, and the effectiveness of interventions. It must also have the authority to investigate complaints, audit system performance, and issue quarterly public reports detailing findings and recommendations for improvements. Aligning this oversight with existing mental health monitoring efforts will enhance the City's ability to coordinate resources, identify system-wide challenges, and implement consistent improvements across all mental health-related services.

Scale up a Housing First program for people with SMI and increase investments in supportive housing.

Evidence strongly suggests that there are many people with SMI experiencing street homelessness who are not in an acute crisis and for whom the offer of permanent, affordable housing – that they can move into immediately – would be enough for them to come inside. While improved outreach can go a long way to building trust, a large part of the reason that building that trust over time is necessary is because outreach workers are not able to offer people what they really want: permanent housing, only a long pathway towards it that many have tried to follow in the past and failed to achieve.

Create a large-scale "Housing First" program with robust wraparound support services for people with serious mental illness experiencing street homelessness.

Housing First is the most effective way to intervene in the cycle of chronic homelessness that many street homeless individuals find themselves trapped within. Research across decades and many cities have found that between 70-90% of Housing First participants are still stably housed two to three years after receiving services, compared to 30-50% of participants in traditional programs.[173] However, there is currently almost no pathway for street homeless New Yorkers to permanent housing other than through the shelter system, creating an insurmountable barrier to permanent housing options for these individuals.[i]

Housing First Case Studies and Key Findings

- Between 70-90% of Housing First participants remain stably housed two to three years after receiving services, compared to 30-50% of participants in traditional programs.
- Mental health challenges and drug dependency are more likely in the chronically street homeless population than in the general shelter population, making the "housing ready" model — that may rely on treatment compliance or the individuals' ability to navigate complicated application processes prior to placement in permanent housing — a challenging threshold for many unsheltered individuals to meet.
- Stable housing enables chronically homeless individuals to pursue their goals and improve their quality of life. Once stably housed, individuals are better able to take advantage of supportive services, like psychiatric and substance abuse treatment, which promotes their long-term housing stability, employment, and recovery. Without stable housing, these goals are much more difficult to achieve.

[i] There are rare instances in which individuals experiencing street homelessness are able to move directly into permanent housing options. Local Law 3 shows that in fiscal year 2024 (7/1/23 – 6/30/24) 188 street homeless individuals were found eligible for supportive housing and 42 ultimately moved into a supportive housing unit. There is no publicly available data on how many, if any, individuals moved into other subsidized permanent housing options directly from the street.

- Individuals in supportive housing programs that emphasized client-centered services, harm-reduction strategies, and open, nonjudgmental dialogue about substance use and its consequences were more likely to retain housing and less likely to report using stimulants or opiates in follow-up interviews.
- Housing First can be successful in breaking the homelessness-jail cycle: participants receiving permanent housing and support services experienced fewer interactions with the police, fewer arrests, and fewer jail stays than those receiving usual care.
- Housing First is a cost-effective strategy to ending homelessness and addressing mental illness. Individuals with serious mental illness who experienced chronic homelessness incur higher public costs per year than those in permanent supportive housing, especially within the criminal justice and healthcare systems.
- Beginning in 2011, Philadelphia began to see a sharp increase in opioid-related deaths. To respond to the growing crisis, in 2016, Pathways to Housing PA launched a pilot program that targeted chronically homeless individuals with opioid addiction. The program combined Housing First with other street outreach strategies, such as needle exchanges and Narcan training and disbursement, and access to medication-assisted treatment (MAT). The program placed 75 chronically homeless individuals in permanent scattered site housing, providing each with a community-based team of peer specialists, case managers, substance abuse counselors, and medical providers. After one year, 100% of participants remained stably housed and 52% received medication assisted treatment or were sober. As of 2022, Pathways to Housing PA had 550 people in its care, and over the course of 5 years, 85% have maintained housing.
- In 2016, the City and County of Denver, Colorado created the Denver Supportive Housing Social Impact Bond Initiative (Denver SIB) to promote housing stability and reduce jail stays among chronically homeless. The initiative targeted individuals who had eight or more arrests over three consecutive years, provided permanent supportive housing, including rental subsidies and intensive support services, to immediately move homeless people into housing. The initiative created a randomized controlled trial in which half of the participants were placed in permanent supportive housing while the other half were referred to traditional services. After three years, 77% of the individuals who moved into permanent supportive housing remained stably housed.

While its scope is limited to a specific population, New York City does have successful experience designing and scaling up a housing first program for veterans with federal support: HUD-VASH (Housing and Urban Development – Veteran Affairs Supportive Housing). The coordinated effort started in 2011 following a federal commitment to end veteran homeless nationwide by 2015. As a direct result, veteran homelessness has declined by 90% since 2011 in New York City, from 4,677 individuals in 2011 to 482 in 2022 and the City has effectively ended veteran homelessness, reaching the national standard of "functional zero" by providing veterans permanent housing within 90 days of entering the shelter system.[174]

Additionally, in November 2022, Mayor Eric Adams announced the Street-to-Housing pilot, which draws on Housing First principles and is funded solely by the City of New York, through existing City contracts. In this pilot, individuals who had been living unsheltered on the street and agreed to enter one of the City's "welcome centers" following end-of-the-line subway outreach became eligible to move into supportive housing units across four developments managed by the Volunteers of America Greater New York (VOA-GNY) in Brooklyn and the Bronx that already had on-site case work and support staff funded through existing City contracts.

Once placed, residents receive wraparound and comprehensive support from these case workers to complete their application for rental assistance and benefits and access mental health and other treatment services. In addition, the City provided 3-months of rental assistance, while staff worked with individuals to quality them for Section 8 or City FHEPs.

As of August 2024, the program had served 130 people with all 81 units enrolled in the pilot currently occupied and 78 leases signed. Of the 130 people served:

- Six residents returned home to networks of support after reconnecting with family and thirteen found alternative housing.
- Seventy-eight residents signed leases and decided to remain in the program.
- Fifty-three of fifty-nine residents who have already lived in their unit for one year, opted to renew their lease. Of the six residents who did not renew, one is deceased, four moved to alternative housing options, and one entered long term treatment.[175]

According to VOA-GNY throughout the demonstration project, they were able to match eligible clients quickly and efficiently to vacant SRO units that had been sitting empty for an average of 568 days. It took an average of 147 days, or about 5 months for clients sign a lease. While this exceeds the 3-month amount of operating subsidy that the City provided, with stronger management and prioritization this timeline could be accelerated.

Despite the overwhelming success of this program, and the demonstrated need for stable housing placements, it has not been expanded since its launch over two years ago. As noted in the Key Challenges section above, there are an estimated 2,500 vacant supportive housing units, concentrated in the older SRO stock. By working with supportive housing and service providers, and through contract modifications or the issuance of a new RFP, the City of New York could quickly scale up this model to address the persistent problem of vacancies in supportive housing

while addressing a core gap on our homeless services for street homeless individuals with serious mental illness.

Create a "Housing First" program with robust wraparound services.

- **Step 1:** Homeless outreach teams refer individuals living on the street or subway who are chronically homeless and offers them an immediate placement at a low-barrier, short term shelter known as a Welcome Center. The outreach worker communicates that through this program the individual will have the opportunity to move into permanent housing without having to enter shelter.
- **Step 2:** Social services staff at the Welcome Center show individuals photos and videos of the SRO unit that they can move into and schedule a tour so they can decide whether the program is right for them. Staff communicate to individuals that they can move into the unit immediately and complete paperwork later.
- **Step 3:** Supportive housing staff provide tenants with a tour of the building showing them staged units so they can begin to imagine their life after they move in. If an individual accepts the offer of the apartment, staff at the building immediately order bedding and other supplies and prepare the unit for move in.
- **Step 4:** If the individual accepts the placement, their new home is immediately readied for occupancy. The unit will have new linens and other household essentials. The City pays the supportive housing provider a three month "unit hold" fee prior to the resident being found eligible for a longer-term rental operating subsidy.
- **Step 5:** Supportive housing staff employ a client centered approach, working with the new resident to better understand their priorities and goals while helping them with any applications needed for funding. This might include assisting residents in replace missing identification documents, establishing public assistance cases, and completing any other assessments required for supportive housing.
- **Step 6:** Once a tenant has been matched to a rental operating subsidy or other supportive housing funding program, a lease signing is scheduled. Through City FHEPs a tenant's portion for an SRO unit is capped at $50 per month, allowing tenants to save additional income. Once the lease is signed, the provider begins to receive monthly rental assistance payments. Tenants are advised that rental subsidies are portable. If they choose, they can move to a larger home in a traditional apartment building if they are able to do so, or they can continue living in their new home as long as they'd like.

The City Should:

1. Expand the recent Street-to-Home pilot operated by Volunteers of America of Greater New York, which moves individuals experiencing street homelessness with serious mental illness directly into vacant SRO units and provides wraparound support services.

2. Bring in additional supportive housing providers, either through the issuance of a Request for Proposal or through negotiating contract modifications of existing service contracts, to immediately scale up this immensely successful pilot program. Contract amendments could allow for more staff, such as additional social workers or nurses, based on the needs communicated by the providers. Work with VOA-GNY staff to create peer led trainings to ensure that best practices from the Street to Home pilot and Housing First principles are applied at the newly expanded model.

3. Repair the vacant supportive housing units that are offline by providing capital dollars to not for profit service providers or utilizing existing City staff at HPD that make Emergency Repairs to get these apartments immediately online.

4. Provide robust wraparound support services to individuals with SMI once they accept a placement into housing. Ensure the coordination of services between mobile treatment programs and supportive housing staff for clients placed in housing first units who are receiving treatment services from existing City or State mental health teams.

5. Provide three to six months of operating subsidy to supportive housing providers as social workers and staff work with individuals who moved into the units to find them eligible for the funding contracts already in place and housing voucher programs, such as City FHEPS or Section 8.

6. Task the CoC to fully incorporate a Housing First model for street homeless individuals with SMI into the City's existing Coordinated Assessment and Placement System and ensure wider adherence to Housing First principles.

7. Establishing shared metrics across providers and rigorously track outcomes of the model, in partnership with the State.

Housing First: A Cost-Effective Strategy

	Daily Cost per person	30 day cost per person
Supportive Housing	$68	$2,040
Shelter	$136	$4,080
Incarceration at Rikers Island	$1,414	$42,420
Hospitalization	$3,609	$108,270

A methodology for the above cost analysis is included in the appendix.

Fulfill the NYC 15/15 commitment to build supportive housing and create more supportive housing through a NY/NY IV agreement.

To ensure that we can both establish a Housing First program and increase the number of permanent supportive housing units available for people exiting the shelter system, the City must redouble its efforts to hit the targets set forth in NYC 15/15 and push to bring additional units of supportive and affordable housing online.

The City should:

- Implement the recommendations to increase efficiency at the City Department of Housing Preservation and Development HPD made by the Office of the New York City Comptroller in a February 2024 Report, *Building Blocks for Change.*
- Work with the SHNNY to implement its recommendations to fulfill on the NYC 15/15 commitment including the reallocation of unawarded scattered site units, the enhancement of NYC 15/15 contract rates and capital subsidy to align with current inflation rates, and the development of a supportive housing preservation program.

The City and State must:

- Recommit to working together to make a shared goal to increase City and State funding for more supportive housing through a new NY/NY IV agreement and the State must increase support for existing supportive housing as advocates have been pushing for over the last several years.
- Work to provide any needed capital funding to make building system improvements to SRO buildings.

Provide supportive housing placements to people with serious mental illness discharged from City jails.

Under BradH, DOC is legally required to submit a supportive housing application for most individuals in detention with SMI. However, the City is under no obligation to successfully place those individuals into housing, and 76% of the time, does not even finish supportive housing applications as legally required.[176] The City's ongoing failure to place individuals with serious mental illness into stable housing with wraparound mental health services disrupts individuals' adherence to treatment plans and too often, leads to recidivism and tragedy.[177]

While the program aims to provide 500 units, as of 2024, approximately 120 units are operational and occupied. These units are distributed across all five boroughs, utilizing two primary models: scattered-site housing, where units are integrated into existing apartment buildings throughout the community, and congregate housing, where multiple residents live in a single building with on-site services. Providers such as Urban Pathways, The Fortune Society, and CAMBA manage these housing units, offering critical support services to residents.[178] The remaining units are under development, supported by the New York City Council's allocation of $6.4 million in the 2025 fiscal year budget to fund the expansion, increasing the per unit budget from approximately $17,000 per year, to $25,600 in line with comparable forms of supportive housing programs in New York City, such as ESSHI. But the demand for supportive housing among justice-involved individuals with serious mental illness continues to far exceed supply. [179]

Just Home, which receives some of its operating funds through the JISH initiative, is a project created by NYC Health + Hospitals (H+H) in partnership with HPD, and The Fortune Society, which seeks to provide supportive housing for individuals recently released from Rikers who have serious medical needs, which may include individuals with mental illness.[j] The program would create 83 units, which includes 58 supportive housing, 24 affordable housing, and 1 live-in super, and will offer on-site services from peer specialists, residential aides, social workers and case managers. The program requires approval by the New York City Council and is facing increasing political opposition.[180]

To effectively end street homelessness for people with serious mental illness, New York City and State must work together to increase supportive housing designed specifically for justice-involved people with serious mental illness.

- The City should set and publicly track a citywide policy to successfully place 100% of people discharged from City jails with serious mental illness into permanent, supportive

[j] According to H+H, the location of Just Home on the Jacobi Hospital campus provides residents with close access to the health services at the hospital and allows for close collaboration between Jacobi medical providers and Just Home case managers. The Correctional Health Services (CHS) will be the sole source of referrals, where they will identify patients who are homeless and in need of housing based on their medical and social needs. Individuals must be released from custody by the courts to be eligible for this housing. Although residents may have a range of case resolutions (e.g. charges dropped; an Alternative to Incarceration agreement; time served), everyone will be out of the City's custody.

housing or the new Housing First program, where appropriate, and rigorously track outcomes of discharged individuals with serious mental illness including housing stability, recidivism rates, and health improvements.

- The New York City Council should immediately approve the Just Home program to bring online83 units of critically needed supportive housing for justice-involved people with complex medical needs, which may include those with serious mental illness.
- The City and State should work together to increase available funding for Justice-Involved Supportive Housing (JISH) and the City should baseline its $6.4 million to allow JISH service providers to permanently align its service rates with other high-need supportive housing programs.[181]

The State must do its fair share to confront the City's homelessness crisis.

New York State and New York City are obligated under the New York State Constitution and a Consent Decree to provide shelter to single adults experiencing homelessness, but New York State has continuously failed to do its fair share, putting significant strain on the City's shelter and supportive housing network. The State should immediately:

- Reverse Cuomo-era budgeting that shifted the cost of single adult shelter almost entirely onto the City to dramatically increase the portion of funds provided by New York State to the City's budget for emergency shelter, stabilization, and safe haven beds. With a State contribution of 47% of the single adult shelter expenses (as it did in 2007), nearly $500 million more would made be available for increased mental health services, better wages for human service worker to improve retention, and improve shelter conditions – including reducing shelter sizes.
- Increase funding for the New York/New York-funded supportive housing units to protect them from rental market pressures.[182]
- Pass the HAVP legislation (S568B/A4021A), which including an allocation of $250 million for the first year of the program through the passage of the New York State budget, at least 50% of these new funds be provided to individuals currently experiencing homelessness and importantly, makes explicit that the voucher be available regardless of immigration status.

Expand and improve involuntary and court-ordered treatment and secure detention programs.

With expanded and more effective proactive outreach and emergency response teams, and with a new Housing First focus, many people living on the street with serious mental illness will be connected voluntarily to the support, services, and housing they need to stabilize and improve their mental health. Evidence shows that Housing First approaches are effective 70-90% of the time to keep individuals stably housed.

However, for a subset of individuals – people living on the street who pose a threat to themselves or others but refuse to accept psychiatric treatment and housing – involuntary hospitalization, secure detention, and court-ordered treatment programs are sometimes necessary. These options must have as their goal both protecting public safety and meeting the needs of the individual.

Close gaps in State law around involuntary hospitalization and AOT to ensure more people receive the care they need.

The expansion of the use of involuntary removals, hospitalization, and treatment cannot be taken lightly and must balance the need to improve public safety with the civil rights and liberties of people in crisis. Over the last three years, City and State leaders have proposed amendments to State law to address perceived gaps in the provision of care that make it challenging to secure involuntary treatment for certain populations. The Governor has proposed several amendments to State law to expand the standard for involuntary removals to capture more people experiencing street homelessness. The Mayor's Psychiatric Crisis Care Legislative Agenda, introduced by State Assembly Member Edward Braunstein proposed sweeping changes to remove barriers to involuntary removals and hospitalization as well as AOT. The H.E.L.P. Act, sponsored by State Senator Brad Hoylman-Sigal and Assembly Member Micah Lasher expands the range of professionals authorized to evaluate individuals for involuntary hospitalization and aims to improve coordination across care providers. The State legislature should prioritize the following amendments to State law to improve coordination and better connect individuals in crisis to the care they need:

- Expand the range of professionals authorized to evaluate individuals for involuntary hospitalization and AOT to include psychiatric nurse practitioners.
- Require hospital administrators to notify community mental health providers who have previously treated a patient when the patient is admitted to a hospital to improve coordination.

- Require practitioners who are evaluating an individual for involuntary hospitalization and treatment to take into account the individual's full medical history and credible reports from social workers and outreach teams that speak to the person's risk.

Expedite and expand secure, outposted therapeutic beds.

Outposted therapeutic beds provide a vital solution for individuals with serious mental illness in custody and are critical to meeting the City's legal obligation to close Rikers Island. These secure, hospital-based treatment units would not only ensure people in City jails with serious mental illness receive the therapeutic and psychiatric treatment they need to improve their mental health but would save millions of dollars in operating costs via saved transportation costs and reduction of acute episodes that trigger more expensive inpatient treatment. Unfortunately, the 360 beds currently underway will only scratch the surface of the need. The City should implement the following in line with the recommendations out of the Lippman Commission:

- Immediately bring online the 100 beds under final stages of construction at Bellevue.
- Work with the State Commission on Corrections to expedite final review and approval of the facilities planned at Woodhull and North-Central Bronx hospitals.
- Increase the City's current commitment to bring the total number of therapeutic beds to 1,500, as recommended by the Independent Rikers Commission. The City and State should prioritize the retrofit of any remaining underutilized hospital beds and new construction and infill on City and State hospital campuses.[k]

Increase the capacity and efficacy of Mental Health Courts.

Mental Health Courts present a promising intervention for justice-involved people with serious mental illness, diverting people from City jails to avoid further decompensation and reducing the likelihood of a rearrest for participants by 46%. The expansion of mental health court programs hinges on the availability and quality of services that can be offered to program participants – including case workers, psychiatrists, and most notably the provision of stable, supportive housing.[183] If an individual is living on the street and unable to be placed in a secure residential facility by a case worker, judges may outright reject their participation in mental health court program with the notion that the individual will be more likely to receive and adhere to treatment

[k] Based on the NYC Health + Hospitals Bed Utilization Report for Fiscal Year 2024, there are, on average, approximately 1,055 unoccupied beds daily across the system's 11 acute care facilities, which have a total of 4,116 staffed beds and an overall occupancy rate of 74.4%. At least some of these over 1,000 unoccupied beds may be repurposed for new therapeutic beds, subject to considerations such as funding, staffing, and specific healthcare needs. Additionally, certain hospital campuses have underutilized land that could be suitable for development. For example, the Sea View Hospital campus on Staten Island has been identified as having potential for redevelopment into a wellness community, which could include facilities for individuals with serious mental illness.

plans in jail than on the street or cycling through the City's shelters.[184] To improve the efficacy of treatment and expand the courts' capacity to serve people experiencing homelessness with serious mental illness, the City and State should work together to:

- Increase funds for court-based mental health diversion programs to improve case management and facilitate program administration. Increased funding would allow court-based programs to hire and retain additional case managers, clinicians, nurses, and social workers to reduce caseloads, improve retention, and enable earlier assessments to avoid backlogs and long waits in jail for potential program participants.
- Increase funding for District Attorney-led diversion programs across all five boroughs to enable earlier referrals into mental health courts and reduce the time potential participants sit waiting in Rikers.
- Guarantee individuals referred into mental health court placements in therapeutic settings including secure and semi-secure residential facilities or if appropriate, supportive housing or housing first units depending on the severity of the charge and the individual's circumstances.
- Develop a consistent citywide evaluation framework for mental health courts to centralize data collection and track short- and long-term outcomes to inform program expansion and improvements over time.

Invest in the City's mental health system and ensure New York State does its fair share.

To improve access to high-quality mental health care for people experiencing homelessness with serious mental illness, the City and State must work together to increase inpatient capacity and other forms of treatment programs such as Extended Care Units (ECUs), make strategic investments in the mental health workforce and nonprofit service providers to reduce staff turnover and burnout, and the reverse of state-level budget cuts that have put significant strain on an already buckling mental health system.

Reverse State-level funding cuts for New York City's mental health system.

Decades of State and Federal cuts to the City's mental health system have taken a serious toll on New York City's capacity to adequately treat people with serious mental illness. These cuts have driven long wait times for the provision of mental health care, especially for low-income individuals experiencing street homelessness, and created deficits at H+H and in the City's public hospital system. To end the crisis of street homelessness for people with serious mental illness, the State must step in to reverse Andrew Cuomo-era budget cuts to the City's mental health system. The State should immediately:

- Increase Medicaid rates to shore up the City's public hospital system and incentivize private health care providers to provide adequate mental health services to the 4 million New Yorkers who are covered by Medicaid.

Invest in the City's mental health and human services workforce.

The City must invest in the City's mental health and human services workforce to confront the City's shortage of mental health professionals and ensure mental health providers across nonprofit and government entities alike are able to attract and retain qualified staff:

- Guarantee workers at City-contracted nonprofit human service providers a living wage and regular cost of living adjustments to reduce worker turnover and burnout.
- Expand tuition assistance and loan relief programs for part-and full-time mental health workers employed by City and State agencies and nonprofits, building off of the success of the Behavioral Health Loan Repayment (BH4NYC) H+H program.[185]
- Expand and empower the City's peer workforce in line with the Colorado Behavioral Health Administration's Crisis Professional Curriculum, which trains peers in crisis assessment, management, de-escalation, and safety planning.
- Introduce a CUNY rotation for social work and psychology students at clubhouse programs, as proposed by Borough President Mark Levine.
- Consider including sabbatical options for mental health care workers into City contracts after a certain length of service to the City of New York to reduce workforce burnout and turnover.

Invest in and adapt mental health care services for people with SMI to fully integrate them into the new Housing First approach and related programs.

The City must prioritize partnerships with private hospitals and targeted investments in promising mental health care programs and practitioners who have the specialized skills needed to serve individuals with SMI at risk of homelessness.

- Create more flexibility in IMT, ACT, and other mobile treatment programs to allow for services to be tapered over time as clients stabilize, with lower staff ratios for individuals who requires less intensive care and dramatically expand step down programs to reduce wait lists and tenure in mobile treatment programs.
- Expand the State's Rehabilitative and Tenancy Support Services program to provide more intensive and step-down mental health treatment to individuals in supportive

housing with SMI, with a particular focus on serving clients in existing scattered site units.[186]

- Coordinate care for AOT participants with ACT and other mobile treatment programs to increase efficacy and improve outcomes.
- Increase City funding for the hiring and retention of psychiatric nurse practitioners at City funded community health centers, public hospitals, and mobile treatment and crisis response teams.
- Continue to expand new treatment facilities that can provide the range of care for individuals with serious mental illness may need, such as the recent addition of Extended Care Unit programs at three H+H sites across the City.
- Partner with private hospitals receiving City and State tax benefits to increase the City's overall inpatient and mental health care capacity.

Conclusion

At its core, homelessness is a consequence of the city's dire housing affordability crisis. Exorbitant housing pricing in New York City make it challenging for anyone to find a stable place to live that they can actually afford. For individuals with serious mental illness cycling in and out of jails, hospitals, and shelters, it can be impossible. Confronting the City's broader housing affordability crisis requires a comprehensive approach that protects tenants from unfair rent increases, harassment, discrimination, and evictions; dramatically increases the supply of housing at all income levels; and invests more in making the possibility of home ownership a reality for more New Yorkers.

For the relatively small population of individuals persistently ending up back on the street, the evidence is overwhelming and clear: housing first works.

But New York City currently has a housing last approach to street homelessness. People with serious mental illness are trapped in an institutional circuit of shelters, hospitals and jails, receiving sporadic and insufficient care and unable to stabilize their lives. People simply can't get better on the streets.

The City of New York must follow the examples of Philadelphia, Denver, Houston and other municipalities throughout the country who are applying an evidence-based approach to ending street homelessness. With stronger management from City Hall and a modest upfront investment, New York can become the first major City in the country to effectively end street homelessness for people with serious mental illness.

Methodology

The Comptroller's Office used direct data from agencies, public data, internal data from Comptroller's Office audits and investigations, as well as interviews with key stakeholders to develop this analysis. The Comptroller's Office received project-level data from the Department of Housing, Preservation & Development (HPD) on the counts of supportive housing unit starts in buildings receiving funding from HPD that has been de-identified and aggregated in order to preserve the privacy of residents living in these facilities. The Office assembled data on supportive housing eligibility and placements by the applicant's current residence from the Coordinated Assessment and Placement System as reported by the Human Resources Administration in compliance with Local Law 3 of 2022. The data are masked for locations with fewer than ten matching persons or individuals; those locations are excluded from this analysis. Data on B-HEARD is derived from reports produced by the Office of Community Mental Health.

The Comptroller's Office June 2023 Audit of the Department of Homeless Services' (DHS) Role in the "Cleanups" of Homeless Encampments provided data evaluating DHS's efforts to engage unsheltered individuals during encampment cleanups and transition them to temporary shelters. The audit reviewed DHS records, observed cleanup operations, and assessed tracking and reporting mechanisms for effectiveness. The audit highlights systemic challenges in addressing homelessness and mental health. From March to November 2022, DHS outreach teams engaged 2,308 individuals, yet only 119 (5%) accepted temporary shelter placements, with 29 leaving the same day. Encampments were rebuilt at 31% of cleared sites, underscoring the cleanups' lack of lasting outcomes. The audit also identified deficiencies in DHS's data tracking, hindering its ability to assess and improve services. These findings highlight the need for person-centered approaches addressing mental health and housing stability, alongside better performance tracking to create sustainable solutions for unsheltered populations. The Comptroller's Office "Housing First" report, released in conjunction with the audit of DHS sweeps of homeless individuals living on the street, evaluated the efficacy of the Housing First model, providing data on the success of the model in other large metropolitan areas to permanently increase the number of people stably housed within their community.

The Comptroller's Office August 2023 audit Review of NYC Shelter System: Focusing on Both 'Pathways In' & 'Pathways Out', examined the Department of Homeless Services' (DHS) processes for shelter entry and exit, focusing on their effectiveness in addressing homelessness, including among individuals with mental health challenges and those experiencing street homelessness. The review analyzed DHS records to evaluate shelter application approvals, lengths of stay, and housing outcomes. It also assessed DHS policies for intake and discharge and included interviews with officials and service providers to understand operational challenges and client experiences, highlighting critical barriers in addressing homelessness and mental health needs. The audit's analysis revealed significant obstacles to shelter access, with DHS denying 80% of family shelter applications in February 2022, often without thoroughly investigating applicants' housing history, leaving many vulnerable individuals without support. Extended shelter stays—averaging over one year—further underscored challenges in transitioning individuals to stable housing. The

audit also found that over 95% of recipients did not return to shelter when placed into subsidized housing, such as supportive housing.

In February 2024, the Office of the New York City Comptroller released an audit, which examined the Department of Health and Mental Hygiene's (DOHMH) management of the of Intensive Mobile Treatment (IMT) program. IMT supports individuals with severe mental health challenges, including those experiencing street homelessness. The audit reviewed DOHMH policies, client records, and performance data, and included interviews with officials and service providers to assess service delivery and oversight. This audit highlights systemic challenges at the intersection of mental health and street homelessness. Key findings include significant gaps in service delivery—only 41% of clients received regular psychiatric care—and a sharp decline in housing stability, with stable housing rates falling from 47% to 30% over 27 months. Additionally, the lack of effective performance tracking hindered DOHMH's ability to monitor outcomes.

The Office of the Comptroller's February 2024 in-depth report, Building Blocks of Change, analyzed staffing challenges and affordable housing production at HPD, interviewing 40 stakeholders including developers, non-profit leaders, current, and former staff to understand the inner workings of the agency and identify core needs. The report included new insight into historical staffing trends at the agency, particularly the acute loss of institutional knowledge during the citywide vacancy crisis that began in 2021. The office additionally matched ten years of data on project starts and completions provided by HPD to public Local Law 44 data to construct a timeline of housing preservation and new construction trends, finding that the destabilizing impact of the Covid-19 pandemic put the city in a significant deficit for housing production.

To supplement this policy analysis, the Office of the Comptroller conducted rounds of interviews with various key stakeholders including mental health professionals and peer workers actively engaged in IMT, Assertive Community Treatment (ACT), AOT, and Alternatives to Incarceration (ATI) programs. We also spoke with individuals working in CPEPs, as well as physicians and researchers within the city's public hospital system who specialize in treating individuals with SMI. Additionally, we consulted professionals from housing programs who provide direct support to individuals experiencing homelessness with SMI, helping them secure housing and connect to vital mental health resources. Finally, we spoke directly with individuals who were previously homeless and living with SMI to understand their lived experiences and insights.

The daily cost of providing supportive housing is based on the annual subsidy available to providers through the State's Empire State Supportive Housing Initiative, https://omh.ny.gov/omhweb/rfp/2022/esshi/esshi-round-seven-rfp.pdf

The daily and 30-day cost of shelter is based on the Mayor's 2023 Management Report, available here: https://www.nyc.gov/assets/operations/downloads/pdf/pmmr2023/dhs.pdf.

The daily cost of providing shelter for single adult facilities is $135.83. The daily and 30-day cost of detaining an individual in custody is based on the Mayor's 2023 Management Report. The average daily population based on that report is 5,559 and the total funding, excluding intracity costs is $2.87 billion. The annual cost was calculated by dividing $2.87 billion by the average daily

population, 5,559. The daily cost is inferred to be $1,414 per person. The daily cost of hospitalization was sourced from the Kaiser Family Foundation, Hospital Adjusted Expenses per Inpatient Day | KFF, which estimates that the average cost of hospitalization per night in New York State is $3,609.

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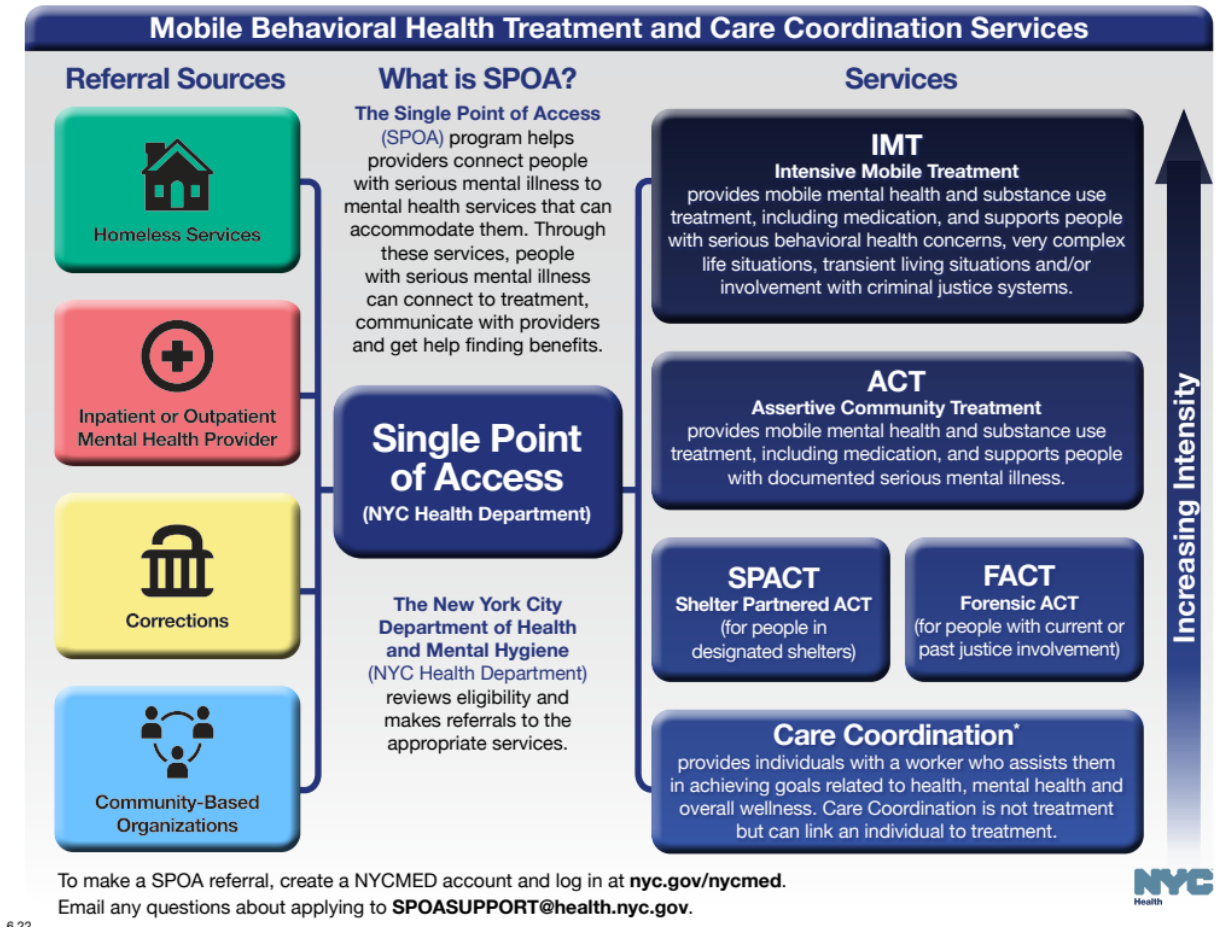
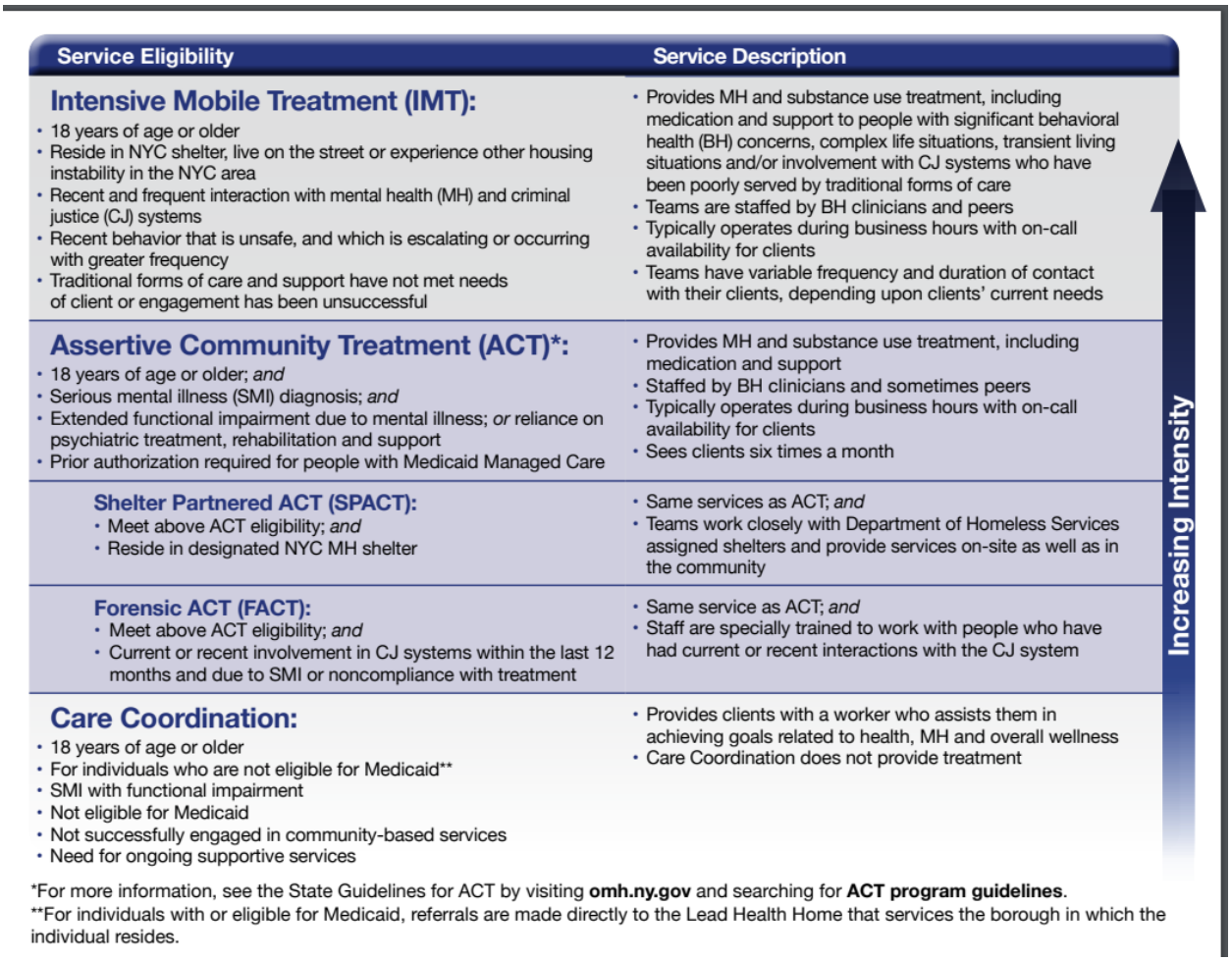
Appendix A


Mobile Behavioral Health Treatment and Care Coordination Services
Referral Sources
Homeless Services
Inpatient or Outpatient Mental Health Provider
Corrections
Community-Based Organizations
What is SPOA?
The Single Point of Access (SPOA) program helps providers connect people with serious mental illness to mental health services that can accommodate them. Through these services, people with serious mental illness can connect to treatment, communicate with providers and get help finding benefits.
Single Point of Access
(NYC Health Department)
The New York City Department of Health and Mental Hygiene (NYC Health Department) reviews eligibility and makes referrals to the appropriate services.
Services
IMT
Intensive Mobile Treatment
provides mobile mental health and substance use treatment, including medication, and supports people with serious behavioral health concerns, very complex life situations, transient living situations and/or involvement with criminal justice systems.
ACT
Assertive Community Treatment
provides mobile mental health and substance use treatment, including medication, and supports people with documented serious mental illness.
SPACT
Shelter Partnered ACT
(for people in designated shelters)
FACT
Forensic ACT
(for people with current or past justice involvement)
Care Coordination*
provides individuals with a worker who assists them in achieving goals related to health, mental health and overall wellness. Care Coordination is not treatment but can link an individual to treatment.
Increasing Intensity
To make a SPOA referral, create a NYCMED account and log in at nyc.gov/nycmed.
Email any questions about applying to SPOASUPPORT@health.nyc.gov.
NYC Health



ACT is recognized as an evidence-based model that delivers treatment and care management through assertive engagement, focusing on recovery while honoring individual preferences. Multidisciplinary teams, including nurses, psychiatrists, social workers, and substance use specialists, collaborate to help clients achieve personalized recovery goals. With a favorable staff-to-client ratio of 10:1, ACT teams can offer flexible, tailored support directly within the clients' communities, fostering the development of essential skills relevant to their daily lives. As of December 2024, there that are currently 76 New York City ACT teams serving approximately 4,179 clients, achieving an 81% capacity utilization.

FACT is a service delivery model that builds upon the ACT framework, specifically designed for justice-involved individuals with serious mental illness (SMI). This model is adapted to address the criminogenic risks and needs unique to this population. FACT teams are multidisciplinary, client-focused, and community-based, integrating criminal justice partners and peer specialists with lived experience within the justice system. FACT teams also include licensed clinicians, criminal justice specialists, criminal justice liaisons, and housing specialists. Referrals to FACT often come from criminal justice stakeholders, including law enforcement, courts, community corrections, and behavioral health collaborators. These individuals may be under arrest and pending court proceedings, incarcerated and awaiting release, involved in treatment and

diversion courts, subject to community supervision (such as probation or parole), or recently released from jail or prison.[187] In NYC, CASES FACT teams receive referrals via the Single Point of Access (SPOA) for ACT and Care Coordination, operated by the DOHMH. Additionally, NYC Safe—a partnership between DOHMH, the DHS, and the NYS Department of Corrections and Community Supervision (DOCCS)— helps refer individuals appropriate for FACT services. A 2017 randomized controlled trial of FACT in New York State showed that participants experienced significantly fewer convictions, fewer days in jail, fewer days in the hospital, and more days in outpatient treatment.[188]

SPACT is a specialized program in New York City designed to provide comprehensive mental health services to individuals with serious mental illness who reside in designated NYC mental health shelters. SPACT aims to address the unique needs of homeless individuals with serious mental illness, helping them to stabilize their condition, access necessary treatments, and potentially transition to more permanent housing situations. SPACT teams offer the same intensive, community-based treatment and support as traditional ACT programs, but with a specific focus on serving residents in mental health shelters.[189]

NMCC is a specialized program designed for children under the age of 21 who have been diagnosed with a serious emotional disturbance but do not qualify for Medicaid. This service aims to provide comprehensive support to these individuals and their families, even without Medicaid coverage.[190]

The IMT program is designed to enhance client retention, decrease incarceration rates, and assist participants in obtaining stable housing. The IMT program operates through mobile treatment teams composed of a program director, behavioral health specialists, a psychiatrist, a nurse, an administrative assistant, and peer specialists, with each team serving a maximum of 27 clients. As of November 2024, 31 IMT teams provide services for a total of 927 clients. Referrals to the IMT program originate from various sources, including jails, hospitals, and community organizations.

Appendix B

New York State Mental Hygiene Law

Section 9.41 of the Mental Hygiene Law authorizes a peace officer or police officer to take an individual into custody for a psychiatric evaluation. Section 9.58 authorizes a Designated Clinician, defined as a physician or other mental health professional who is a member of an approved mobile crisis outreach team to remove or direct the removal of a person to a hospital for a psychiatric evaluation. According to OMH's memorandum, both sections 9.41 and 9.58 authorize the removal of a person who appears to be mentally ill and displays an inability to meet basic living needs, even when no recent dangerous act has been observed.

If an individual is brought or goes directly to a CPEP, which are governed by section 9.40 of the Mental Hygiene Law, they must undergo an evaluation by a staff physician within 6 hours and a staff psychiatrist must confirm the first doctor's findings within 24 hours. If the patient is found to have a mental illness for which immediate observation, care and treatment in a CPEP is appropriate *and* which is likely to result in serious harm to themselves or others they can be held for a up to 72 hours. After 72 hours, the patient is either discharged or undergoes further evaluation under Sections 9.39 or 9.27 of the MHL. If it is determined that the individual meets either of those Emergency Standards they can be held for an additional 15 (9.39) or 60 days (9.27) in a different facility.

If a person is brought to an emergency room, the process is dictated in Section 9.39 of the MHL. Individuals brought in by crisis outreach teams or police in New York State typically go through this process. A physician must determine if the person meets the emergency standard prior to admission. If the patient is found to have a mental illness for which immediate observation, care and treatment in a hospital is appropriate and which is likely to result in serious harm to themselves or others they can be held for 48 hours. Within 48 hours a staff psychiatrist must confirm that the individual meets the emergency standard, after which time they can be admitted into a psychiatric inpatient facility for up to 15 days. The individual can be held past the 15 days if they meet the Involuntary Standard and their admission is converted to an admission through the process laid out in MHL 9.27, which allows them to be held for an additional 60 days.

Involuntary treatment for 60 days (9.27) requires certification from two physicians confirming the individual has a mental illness for which care and treatment in a mental hospital is essential to their welfare; that the person's judgment is too impaired for them to understand the need for such care and treatment; and as a result of their mental illness, the person poses a substantial threat of harm to self or others. For involuntary retention beyond the initial 60-day period, the hospital must petition the court, demonstrating that the individual poses a substantial threat of harm to themselves or others. If approved, retention can extend for up to six months, with regular judicial reviews. Individuals in this category are entitled to legal representation and may request hearings to challenge their retention.

Kendra's law, Section 9.60 of the New York State Mental Hygiene Law, established a statutory framework for Assisted Outpatient Treatment (AOT), a court-ordered, involuntary outpatient treatment program for individuals with serious mental illness. AOT participants often have a history of psychiatric hospitalizations, incarcerations, or arrests and is targeted to individuals who are unlikely to voluntarily seek treatment and who pose a potential threat of serious harm to themselves or others. The program seeks to ensure these individuals receive necessary psychiatric care even if they initially refuse treatment.

The process for issuance of AOT orders begins with the filing of a petition in the supreme or county court. A wide range of people may act as petitioners, including but not limited to adult family members, hospital directors, qualified psychiatrists or other mental health workers, nonprofit directors, or parole or probation officers. To qualify for AOT,[191] an individual must meet a long list of criteria, including a clinical determination that the individual is "unlikely to survive safely in the community without supervision" and a recent history of at least two psychiatric hospitalizations or treatment in a correctional mental health unit, among other qualifications. [l]

Implementation of AOT is a collaborative effort between the New York State OM), its five regional Field Offices, and local mental health authorities across New York State; DOHMH manages the program in New York City. Once an AOT order is issued, recipients must be escorted home from the hospital or court and connected to treatment services through a face-to-face meeting within one week. Providers generally meet with AOT recipients weekly after this initial meeting to ensure compliance with the treatment plan. Providers are also required to report significant events that may affect compliance, such as arrests, homelessness, or refusal of medications, to Local Governmental Units (LGUs) within 24 hours.

LGUs must report serious incidents, such as weapons possession or domestic violence, to OMH Field Offices, which enter the information into the Tracking of AOT Cases and Treatments (TACT) system. OMH uses TACT data to monitor compliance, address challenges, and intervene when necessary.[192] Noncompliance with AOT may result in a physician requesting that the director of community services arrange for the individual to be transported to a hospital for evaluation. This can involve law enforcement, ambulance services, or mobile crisis teams. Once admitted, the individual can be held for up to 72 hours to determine whether involuntary inpatient

[l] No person may be placed under an AOT order unless the court finds clear and convincing evidence that the subject meets all of the following criteria: is at least 18 years old; is suffering from a mental illness; is unlikely to survive safely in the community without supervision, based on a clinical determination has a history of lack of compliance with treatment for mental illness; is, as a result of mental illness, unlikely to voluntarily participate in the outpatient treatment that would enable them to live safety in the community; in view of their treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others; and is likely to benefit from AOT.

hospitalization is warranted following their incompliance with AOT. If the criteria are not met, the person must be released.

AOT orders are valid for up to one year and can be renewed if the individual continues to meet the eligibility criteria. LGUs must notify OMH of their decision to pursue renewal and petition the court at least 30 days before the order's expiration. If the individual no longer meets the criteria, the LGU must provide OMH with a reason for non-renewal.

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