Testimony of
Coalition for the Homeless

before the Fiscal Committees
of the NYS Legislature

NYS Executive Budget Proposal
For Mental Hygiene 2024

submitted by

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The Coalition for the Homeless ("Coalition") respectfully submits this testimony to express our positions on several provisions of the Governor's proposed budget relating to behavioral health. Founded in 1981, we are the court-appointed independent monitor of the New York City ("NYC") Department of Homeless Services ("DHS") shelter system for single adults, the City-appointed independent monitor of the shelter system for homeless families, and plaintiff in the historic *Callahan v. Carey* case that first guaranteed the legal Right to Shelter. As such, the opinions set forth below are informed by our more than 40 years of experience operating frontline programs for the most vulnerable individuals and defending the fundamental rights of those disproportionately impacted by the intersection of homelessness and mental health challenges.

Involuntary Treatment

Recent tragedies involving homeless people experiencing mental health crises have renewed calls to expand involuntary inpatient and outpatient commitment. The fact is that these tragedies highlight the failures of our broken and insufficient mental health systems, not the need for forced treatment. Thousands of New Yorkers have no access to the community-based services they need, even when they are begging for them. If New York State is serious about preventing future tragedies, then it must invest in the services to meet the existing need.

The Governor's proposal to expand involuntary commitment and flood the subways with police will not permanently reduce the number of people with untreated serious mental illness sleeping on the streets and subways. Hospitalization and policing are costly and do not address the fundamental reason that drives people to sleep on the streets and subways: the lack of housing, paired with voluntary mental health treatment services that are designed to meet the individual need of each person. The City is not adequately tracking the outcomes of the over 7,000 involuntary removals conducted by police and outreach teams in 2024, failing to provide consistent data on whether people who are removed are actually admitted to the hospital, let alone outcomes after hospital discharge.[1] This begs the question of why changes are being sought to expand the law when the City cannot account for how the existing law is being used.

Psychiatric hospitalization is not a long-term solution for serious mental illness (SMI), and is obviously not a solution to homelessness. A person cannot be treated in a hospital forever, and when they eventually leave, they are rarely connected to the housing and community-based services that they need to maintain health and stability in the long term. Accordingly, a plan that hinges largely on forced psychiatric hospitalizations is short-sighted.

Without adequate housing, people will continue to live on the streets and subways. There is not enough supportive housing to meet the needs of homeless people and there are steep barriers to successfully obtaining the supportive housing that exists. Out of 955 people who were living on

[1] Mayor's Office of Community Health, The City of New York. "2024 Annual Report of Involuntary Transports." 31 Jan 2025. https://mentalhealth.cityofnewyork.us/?sdm_process_download=1&download_id=7069

the streets and subways and being tracked by New York City over several months last year, only 18 percent (175) were placed in a unit.[2]

Furthermore, involuntary treatment does not reduce homelessness. In fact, based on available figures, only 29 percent of involuntary outpatient treatment recipients have had an episode of homelessness at some point in their entire life prior to involuntary treatment.[2] This is supported by the City's own recent report showing about the same percentage of clinician-initiated involuntary transports in 2024 were people experiencing homelessness (and an even smaller fraction of NYPD-initiated ones involving homeless individuals). Even so, thirteen percent of involuntary outpatient treatment recipients were homeless at their most recent follow-up, suggesting how ineffectual such treatment is at addressing homelessness.[3]

In addition, there are long waiting lists for intensive, community-based treatment for serious mental illness. For instance, there are 1,424 people on the waiting list for Assertive Community Treatment (ACT) in New York City as of October 24, 2024.[1] ACT treats people with serious mental illness by assigning a dedicated team of mental health professionals to provide treatment, rehabilitation, and case management. It allows people to receive services in the community, rather than in a more restrictive and more expensive hospital setting. The current waiting list means people wait months, and sometimes years, to be assigned a team and begin receiving support.

The expansion of involuntary commitment criteria will not increase the number of individuals admitted to psychiatric inpatient care. Even voluntary patients cannot secure admissions when they are in crisis, owing to the lack of inpatient capacity. In fact, there are fewer inpatient psychiatric beds today than in 2014.[3] While the 2023-2024 State Budget provided for the addition of 150 psychiatric beds, only two of those beds are in New York City. Further, even though the 2024-2025 Budget provided an additional 200 State-operated psychiatric beds, the locations have not been announced and there is no announced timeline for the opening of those beds.

Involuntary treatment does not yield better outcomes than voluntary treatment with the same services. Gold-standard randomized controlled trials, including one conducted at NYC's Bellevue Hospital, have found that "the two most salient factors in reducing recidivism and problematic behavior among people with severe mental illness appear to be enhanced services and enhanced monitoring."[3] To say it differently, it's the intensive services, not the court-ordered nature of involuntary treatment, that makes a difference. Furthermore, a recent audit conducted by the State Comptroller's office found glaring issues with the Office of Mental Health's

[2] The Office of Mental Health does not track the number of people who are homeless at the time they begin involuntary treatment.
[3] M. Susan Ridgely, Randy Borum and John Petrila, *The Effectiveness of Involuntary Outpatient Treatment*, RAND CORP., 2001, at p. 27 available at https://www.rand.org/pubs/monograph_reports/MR1340.html.

("OMH") implementation of outpatient commitment under Kendra's Law – including frequent lapses in treatment and delays initiating assessments, in some cases by over two years.[4]

There also are significant racial disparities in involuntary commitment orders. As of January 10, 2025, over three out of five involuntary outpatient commitment orders statewide, and over four out of five involuntary outpatient commitment orders downstate, involve people of color.[5] At the same time, people of color lack access to quality, voluntary mental health care, according to a 2024 study.[6] There is no clearer evidence of the failure of our public mental health system to successfully serve people of color.

BUDGET RESPONSES

In light of the foregoing, we strongly oppose all proposals to expand involuntary treatment and urge the legislature to fund services that are effective in housing and treating people with serious mental illness who are sleeping on the streets. As the ongoing severe and historic affordable housing crisis combined with a tattered and poorly functioning mental health system continue to *literally* leave thousands of needy New Yorkers out in the cold, the impact of the Governor's rhetoric about homeless individuals with serious mental illness serves no purpose but to further stigmatize unhoused individuals.

If the State is serious about addressing the needs of those sleeping unsheltered – a concern we share – then it must invest in evidence-based solutions, including:

- **Investing in Housing First programs.** The Housing First approach is an evidence-based model that is proven to successfully and quickly move unsheltered people off the streets and into permanent housing without barriers or unnecessary pre-conditions, while connecting them with the services they need to achieve long-term stability. The approach also ensures that application processes are as simple and easy to complete as possible and that providers work with great urgency to help people access safe and stable housing as quickly as possible while centering the household's choices and needs.
    - Housing First is the most effective permanent housing model proven to work for those who have found that shelters do not meet their needs and have had to sleep in public spaces.
    - New York ceased funding this successful model but should reinstate it immediately to provide at least 750 beds in New York City, adequately funded at $50,000 per unit per year for housing and services. This is less expensive than flooding the subways with police officers and will have better outcomes.
- **Adding 14 new Flexible ACT Adult teams in New York City.** ACT teams provide intensive, continuous, flexible support and treatment to individuals with serious mental illness who have not been successfully engaged by the traditional mental health system.

[4] OFFICE OF THE N. Y. STATE COMPTROLLER, OVERSIGHT OF KENDRA'S LAW – Report 2022-S-43 (Feb. 2024), available at https://www.osc.ny.gov/state-agencies/audits/2024/02/08/oversight-kendras-law.
[5] New York State, Office of Mental Health. "Characteristics of Recipients: Demographics." https://my.omh.ny.gov/analytics/saw.dll?dashboard#reports.
[6] Harvard Medical School. "News: Racial Disparities in Mental Health Care for Medicaid Beneficiaries with Schizophrenia" 20 Jun 2024. https://hcp.hms.harvard.edu/news/racial-disparities-mental-health-care-medicaid-beneficiaries-schizophrenia.

ACT teams serve individuals in their communities, including unsheltered people. The teams provide mental health, substance use, case management, and peer services including psychiatric treatment and medication, and facilitate connections to housing and supportive services.

- As previously noted, there are over 1,400 people on the waitlist for ACT teams in New York City. To meet this existing demand, fourteen new teams are needed, at a start-up cost of $9.1 million, ongoing Medicaid reimbursement costs of $21.4 million, and $5 million in net deficit funding.
- These teams could begin operation within six to seven months of funding allocations.

Thank you for the opportunity to submit testimony. We look forward to working with the Legislature on the budget and other legislation to address the needs of those who are unsheltered or precariously housed throughout the State.