Improving Care Coordination for Homeless Individuals with Severe Mental Illness in NYC

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Executive Summary

Concerns around street homelessness and public safety in New York City are at an all-time high. The public's unease is driven primarily by encounters with individuals in public spaces who are in evident psychiatric distress. It is well-documented that lack of access to comprehensive, high quality mental healthcare perpetuates and prolongs homelessness.

The City can more effectively assist individuals in psychiatric distress *and* reduce street homelessness by improving coordination between shelters, community mental health providers, and hospitals to ensure continuity of care and treatment. Working together, these entities can ensure more appropriate interventions tailored to the needs of the individual in crisis, including, as necessary, hospital admission, discharge planning, dedicated outpatient care coordination teams, and/or Assisted Outpatient Treatment (AOT).

Two thirds of homeless New Yorkers have some measure of "mental health needs"[1] and about 17% have a "severe mental illness."[2] While most can be treated with community-based outpatient care, a small percentage can at times pose a substantial threat of harm to themselves or others as a result of their mental illness. In these instances, hospitals with inpatient psychiatric units are best positioned to treat a patient during an acute psychiatric episode.

Inadequate Inpatient Capacity

However, over the last ten years, the availability of inpatient psychiatric care in New York State has diminished significantly. Between October 2014 and December 2018 alone, local hospitals in New York State closed 597 out of 8,528 beds, or more than 7% of the total capacity in the state.[3,4]

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[1] Routhier, Giselle. "State of the Homeless 2020." *Coalition for the Homeless* online. 2020. https://www.coalitionforthehomeless.org/state-of-the-homeless-2020/.

[2] "HUD 2020 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations." *US Department of Housing and Urban Development*, online. January 27, 2020. https://files.hudexchange.info/reports/published/CoC_PopSub_CoC_NY-600-2020_NY_2020.pdf.

[3] "County Capacity and Utilization Data Book – Calendar Years 2013-2014." *New York State Office of Mental Health – Office of Performance Measurement and Evaluation*. January 2015. https://omh.ny.gov/omhweb/special-projects/dsrip/docs/countyutilization2014.pdf.

[4] "County Capacity and Utilization Data Book – Calendar Years 2017-2018." ." *New York State Office of Mental Health – Office of Performance Measurement and Evaluation*. May 2019. https://omh.ny.gov/omhweb/special-projects/dsrip/docs/county_utilization_data_book.pdf.

Closures have been driven primarily by changes in Medicaid reimbursement methodologies that disincentivize hospitals to offer inpatient psychiatric care,[5,6] as well as recent conversions of psychiatric beds into emergency ICU beds for COVID patients.[7]

Lack of access to inpatient care (and poor care coordination with community providers if a client *is* admitted) leads to increased homelessness, incarceration, and more frequent hospital visits (along with the higher costs associated with these interventions).[8] Reduced capacities and poor Medicaid reimbursement incentive structures for inpatient facilities place significant strain on the facilities that do exist, and encourage hospitals to discharge patients prematurely – if they get admitted at all. This also increases the burden on already-overwhelmed hospital emergency departments (EDs) to provide acute psychiatric care.[9]

Challenges Securing AOT

Following an inpatient stay, Assisted Outpatient Treatment (AOT), or court-mandated mental health treatment, can support an effective discharge and help to prevent future hospitalizations. AOT treatment plans must include care coordination from programs like Health Home Plus, Assertive Community Treatment (ACT) and Intensive Mobile Treatment (IMT). They may or may not also include recommendations for: medication; group, individual, and/or family therapy; alcohol or substance abuse treatment; educational/vocational training; day programming; drug testing; and/or supervised living arrangements. AOT recipients show a 63% reduction in reported episodes of homelessness, a 66% reduction in hospitalizations, and a 73% reduction in incarceration.[10] AOT recipients also show a significant reduction in "harmful

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[5] "New York State Medicaid Update – July 2013 Volume 299 – Number 8." *New York State Department of Health*, online. July 2013. https://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-07.htm#new.

[6] "A Crisis in Inpatient Psychiatric Services in New York State Hospitals" [White paper] *New York State Nurses Association*. 2020.
https://www.nysna.org/sites/default/files/attach/ajax/2020/08/Psych%20Whitepaper%20NYSNA.pdf

[7] Uppal, Amit, David M. Silvestri, Matthew Siegler, Shaw Natsui, Leon Boudourakis, R. James Salway, Manish Parikh, Konstantinos Agoritsas, Hyung J. Cho, Rajneesh Gulati, Milton Nunez, Anjali Hulbanni, Christine Flaherty, Laura Iavicoli, Natalia Cineas, Marc Kanter, Stuart Kessler, Karin V. Rhodes, Michael Bouton, and Eric K. Wei. (2020). "Critical Care And Emergency Department Response At The Epicenter Of The COVID-19 Pandemic." *Health Affairs, 39*(8), 1443-1449
https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00901

[8] "Focus on Health: Making Mental Health Count." *OECD*. July 2014. https://www.oecd.org/els/health-systems/Focus-on-Health-Making-Mental-Health-Count.pdf.

[9] Kalter, Lindsay. "Treating Mental Illness in the ED." *AAMC News*, online. September 3, 2019. https://www.aamc.org/news-insights/treating-mental-illness-ed.

[10] "AOT Recipient Outcomes Summary." New York State Office of Mental Health. *New York State Office of Mental Health*. Accessed November 12, 2021.
https://my.omh.ny.gov/analytics/saw.dll?Dashboard&PortalPath=%2Fshared%2FAOT%2F_portal%2FAssisted%20Outpatient%20Treatment%20Reports&Page=Recipient%20Outcomes

behaviors," including substance use, attempted suicide, property destruction, public disturbances, threats of physical violence, physical abuse/assault, verbal assault, as well as reduced incidences of being victims of physical or sexual abuse themselves.[11]

In practice, however, the process of obtaining AOT orders or an ACT/IMT team for a client is extremely difficult for community providers without help from hospitals. Hospitals file 84% of AOT petitions, and City AOT program representatives admit that it is nearly impossible for community-based providers to file successfully without help from the hospital. [12] When community providers refer clients to receive voluntary ACT and Intensive Mobile Treatment (IMT) services, they often sit on the waitlist for six to twelve months.

Over the past five years, New York City has seen an 8% decrease in the number of individuals under AOT orders.[13] We believe this may have contributed, in part, to increased instances of homeless individuals in clear psychiatric distress, and a growing public concern about homeless individuals who are mentally ill and living in public spaces.

Challenges Securing Inpatient Care

Community care providers have increasingly experienced situations in which New York City hospitals appear to avoid psychiatric admissions from homeless individuals with Serious Mental Illness (SMI). Even when individuals do have AOT orders, or an ACT/IMT team, hospitals have on occasion refused to admit clients, saying their suicidal ideation was "not serious," or that they "jeopardize[d] the safety of our staff and other patients." Rather than arrange for appropriate transfers, hospitals have discharged clients without coordinating with the community-based providers and shelters that serve the individuals.

The lack of inpatient beds in New York City combined with hospitals' apparent refusal or inability to coordinate with community providers is leading not only to poor health outcomes, but also to increased criminalization of mental illness amongst homeless New Yorkers. Today in the United States, an individual with an SMI is three times more likely to be incarcerated rather than hospitalized.[14] Over 40% of detainees in New York City's jail system receive a mental health diagnosis[15]; of that, about one third (or 16% of the total jail population) has an SMI.[16]

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[11] "AOT Recipient Outcomes Summary."

[12] Swartz, Marvin S., Jeffrey W. Swanson, Henry J. Steadman, Pamela Clark Robbins, and John Monahan. "New York State Assisted Outpatient Treatment Program Evaluation." *New York State Office of Mental Health*. June 30, 2009. https://my.omh.ny.gov/analyticsRes1/files/aot/aot-2009-report.pdf.

[13] "AOT Program Statistics: Recipients under Court Order." *New York State Office of Mental Health – Tracking for AOT Cases and Treatments (TACT).* Accessed November 16, 2021. https://my.omh.ny.gov/analytics/saw.dll?Dashboard&PortalPath=%2Fshared%2FAOT%2F_portal%2FAOT%20Assisted%20Outpatient%20Treatment%20Reports&page=Program%20Statistics%20-%20Court%20Orders

[14] Torrey, E. Fuller, Aaron D. Kennard, Don Eslinger, Richard Lamb, and James Pavle. "More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States." Treatment Advocacy Center, May 2010. https://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

The pressures on hospitals are immense, but when they neglect challenging and unprofitable patients, it is up to city officials to investigate, hold providers accountable to their duty of care, and ensure there is adequate staffing and resources to do so.

Recommendations

We propose that city officials take the following steps to address the challenges identified in our analysis above:

1. Establish standard policies and procedures, as well as a communication structure for hospitals and community care providers to:
    a. Obtain appropriate and expedient psychiatric admissions for homeless clients with Serious Mental Illness (SMI), with significant input from community service providers who have day-to-day experience working with the individual
    b. Require notification to community clinicians upon admission from another source
    c. Develop a community care plan prior to discharge in collaboration with community service providers which should include, when appropriate, petitioning for an AOT order or expediting an IMT/ACT team application
2. Establish a simple and direct process for homeless service and community care providers to report inappropriate discharges, admission refusals, and EMTALA (Emergency Medical Treatment and Labor Act) violations to city officials
    a. Establish an independent panel of community care providers and hospital staff to investigate these violations and issue appropriate disciplinary actions for facilities involved in negligence
3. Ensure that adequate resources are available for hospitals to treat patients who need care:
    a. Institute minimum staffing requirements to ensure the safety of patients and employees
    b. Institute minimum staffing requirements to coordinate patient transfers to appropriate inpatient psychiatric facilities or crisis stabilization centers
    c. Institute higher minimums for the number of inpatient psychiatric beds that must be available across New York City hospitals
    d. Create dedicated units for individuals who need longer periods of inpatient care than the typical 4-6 day stay, but who do not meet standards for long-term institutional stays

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[15] Khurshid, Samar. "How the City's New Jails Plan Accounts for Those with Serious Mental Illness." *Gotham Gazette*. November 8, 2019. https://www.gothamgazette.com/city/8910-how-city-close-rikers-jails-plan-serious-mental-illness.

[16] Ford, Elizabeth B., Kevin D. Silverman, Angela Solimo, Y. Jude Leung, Allison M. Smith, Connor J. Bell, and Monica Katyal. "Clinical Outcomes of Specialized Treatment Units for Patients With Serious Mental Illness in the New York City Jail System." *Psychiatric Services* 71, no. 6 (June 1, 2020): 547–54. https://doi.org/10.1176/appi.ps.201900405.

    e. Lobby state government to amend Medicaid reimbursement structures for inpatient psychiatric care
    f. Lobby state and federal government to raise minimums for the number of inpatient psychiatric beds that must be available state and nationwide
4. Assess potential streamlining of the AOT petition process to reduce reliance on hospitals and allow community providers more agency to advocate for their patients
5. Invest in and expand access to non-emergency crisis resources such as crisis diversion centers
    a. Allow walk-ins and community referrals to NYC Support and Connection Centers
    b. Expand the number of centers to at least one per borough
6. Maintain steady funding and resources for outpatient and community care
    a. Increase the number of IMT/ACT teams and reduce wait times to obtain a team

Mental Illness in NYC's Homeless Population

Though it is difficult to obtain exact numbers, there is an undisputed correlation between homelessness and mental illness. SAMHSA data indicates that nationally, about 30% of chronically homeless single adults have mental health conditions.[17] In 2017 and 2018, the Coalition for the Homeless surveyed street homeless individuals in New York City; of those surveyed, two thirds were assessed to have "mental health needs."[18] According to HUD data from January of 2020, about 17% of all homeless New Yorkers have a "severe mental illness,"[19] up from 13% in 2015. This is not to say that mental illness causes homelessness; a majority of mentally ill individuals with SMI remain housed. These numbers do indicate, however, that untreated mental illness, often resulting from a lack of access to comprehensive, high quality mental health services, does contribute to and perpetuate mass homelessness.

Ensuring the most vulnerable New Yorkers obtain adequate mental health care requires coordination and accountability between street outreach and homeless service providers, community mental health providers and, critically, hospitals.

Deinstitutionalization has been the dominant policy shift amongst countries in the Organization for Economic Cooperation and Development (OECD), and that shift to outpatient community care has led to positive outcomes for the majority of mentally ill individuals.[20] Homeless service providers work both in the field and in shelters to identify individuals in need of mental health care, encourage them to seek treatment, provide referrals to community care outpatient

[17] "Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States." *Substance Abuse and Mental Health Services Administration*. July 2011. https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf.

[18] Routhier

[19] "HUD 2020 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations."

[20] "Focus on Health: Making Mental Health Count."

providers, and even offer direct assistance with attending appointments and managing medications.

But not all mental health consumers can prosper on their own in outpatient settings. In a 2014 study, the OECD noted that rapid deinstitutionalization in the absence of proper care coordination has led to increased homelessness, inappropriate incarceration, and frequent hospital admissions amongst individuals with "severe mental illness."[21]

Despite the best efforts of community care providers in New York City, not all clients consent to mental health treatment or care coordination, often because of trauma they have experienced previously within the healthcare and social services systems. Some individuals lack insight into their condition and are resistant as a direct result of delusions and hallucinations that are features of their mental illness. And while the ideal scenario is for everyone in our community to receive the mental health care they need, many individuals who are resistant to treatment do not pose substantial threat of danger to self or others, and the right to bodily autonomy must be respected.

For that very small percentage of individuals who do, however, pose a danger to themselves or others as a result of untreated mental illness or an acute psychotic episode, outpatient community care is not enough. In these instances, hospitals equipped with a Comprehensive Psychiatry Emergency Program (CPEP), as well as state and private psychiatric centers with inpatient psychiatric beds are best positioned to treat a patient during a severe mental health crisis. Hospitals are also essential players when it comes to providing effective discharge planning and preventing future hospitalizations.

Reduction of Inpatient Care

There is little dispute that there is a shortage of inpatient psychiatric beds respective to need in the United States, nor that this scarcity is a direct result of deinstitutionalization policies following the Community Mental Health Act of 1963.[22] Adjusted for population growth, the number of people living in public psychiatric hospitals decreased by about 92% between 1955 and 1994.[23] This movement toward community-based services was, in part, facilitated by advances in medication and treatment that greatly reduced the need for long-term institutional care. Overall, this shift has been a great success for most consumers, family members and the community.

But in the past ten years, the reduction in inpatient psychiatric capacity appears to have weakened the system's ability to respond to people in psychiatric crisis. In 2009, New York

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[21] "Focus on Health: Making Mental Health Count."

[22] Kalter

[23] Torrey, E. Fuller. "Deinstitutionalization: A Psychiatric 'Titanic,'" 1997. https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html.

State began implementing recommendations from the Berger Commission report to further reduce inpatient care in favor or more “efficient” outpatient and ambulatory care.

According to reports released by the New York State Office of Mental Health, the New York State licensed inpatient capacity in October of 2014 was 8,064 or 52.4 beds per 100,000 people statewide. In New York City, capacity was 4,020 or 60.8 beds per 100,000 people.[24] By December 2018, however, the statewide inpatient capacity was reduced to 7,467 or 47.8 beds per 100,000 people, and the citywide capacity was reduced to 3,763 beds or 55.2 beds per 100,000 people. [25, 26]

This means that between October 2014 and December 2018, New York State lost 597 beds, more than 7% of the total capacity. New York City alone lost 257 licensed inpatient psychiatric beds, more than 6% of their capacity.

Beginning in 2010, New York State also changed the Medicaid reimbursement methodology for inpatient psychiatric stays so that inpatient stays longer than 12 days are reimbursed at significantly lower rates,[27] effectively incentivizing hospitals to discharge psychiatric inpatients sooner – if there is a bed for them at all. On the whole, net patient revenue (NPR) for inpatient psychiatric discharges decreased 20.9% between 2000 and 2018; NPR per bed decreased 12% during the same period. In 2018, the average NPR for a psychiatric inpatient bed was just under $100,000, while the average NPR per bed across all hospital beds was around $1.6 million. [28] With these numbers, it is easy to imagine why hospitals are reluctant to serve psychiatric patients in favor of more profitable services. The purpose of this Medicaid reimbursement restructuring had been to improve community care and to incentivize a reduction in hospital admissions, but the change had broader, unintended consequences that poorly impacted emergency psychiatric care and overall mental health outcomes.

More recently, inadequate availability of inpatient psychiatric services has been exacerbated by the COVID-19 pandemic, when acute hospitals were permitted to convert psychiatric beds to emergency ICU beds for COVID patients.[29] These conversions were intended to be temporary, but higher reimbursement rates for medical beds discourages hospitals from returning these beds to psychiatric use.

Reduced availability of psychiatric beds in general hospitals as well as private and state psychiatric centers means increased pressure on emergency departments, which are forced to

[24] “County Capacity and Utilization Data Book – Calendar Years 2013-2014.”

[25] “County Capacity and Utilization Data Book – Calendar Years 2017-2018.”

[26] “County Capacity and Utilization Data Book – Calendar Years 2017-2018.”

[27] “New York State Medicaid Update – July 2013 Volume 299 – Number 8.”

[28] “A Crisis in Inpatient Psychiatric Services in New York State Hospitals”

[29] Uppal et al.

resort to more frequent instances of what is referred to as "patient boarding." When patients in psychiatric crisis report to an emergency department, they are frequently kept waiting in the ED for days at a time, until staff can secure an available inpatient psychiatric bed. Sometimes the only bed that can be secured is miles outside the city, leading to even more disruptions in coordination and communication between the treating hospital and community providers.

One cannot deny the mounting logistical and financial pressures hospitals face, but New York City homeless service and community care providers have also noted increasing instances of hospitals refusing to admit or arrange for appropriate transfers for homeless individuals with SMI.

According to a report from the Treatment Advocacy Center, "The present fiscal incentives encourage states to empty hospitals, even if the patients end up in jails or homeless; there are no fiscal incentives to follow up and make sure the patients receive care once they leave the hospitals."[30] New York City and State can impose financial consequences and incentives to reward responsible care and positive patient outcomes. But even in the absence of financial incentives, city government can also implement policies and accountability measures to incentivize hospitals to better serve the city's most vulnerable, mentally ill residents.

Assisted Outpatient Treatment (AOT)

Assisted Outpatient Treatment (AOT), or court-mandated mental health treatment, can be an effective tool to improve discharge planning after an acute psychiatric episode and can help to prevent future hospitalizations. In 1999, New York State passed "Kendra's Law," named after Kendra Webdale, a woman who died after she was pushed in front of a New York City subway train by an individual with untreated mental illness. Kendra's Law establishes a procedure to obtain AOT orders for individuals suffering from mental illness who pose a danger to themselves or others.[31] Over the past five years, however, New York City has seen an 8% decrease in the number of individuals under AOT orders, from 1,610 in December 2017 to 1,482 in December 2021. [32]

AOT orders are most effectively obtained when petitioned by a hospital during an individual's inpatient psychiatric stay, though in theory, any adult who has regular personal contact with an individual suffering from mental illness can petition for that individual to be placed under AOT. Petitioners can include: an adult parent, spouse, child, sibling, or roommate; a hospital director, a director of a public/charitable organization; a psychiatrist, psychologist, or licensed social worker treating the individual for mental illness, a parole officer, or a social services official. In

[30] Torrey et al.

[31] "Assisted Outpatient Treatment." *New York State Office of Mental Health*. Accessed November 16, 2021. https://my.omh.ny.gov/analytics/saw.dll?dashboard&PortalPath=%2Fshared%2FAOTLP%2F_portal%2FAssisted%20Outpatient%20Treatment%20Reports&nquser=BI_Guest&nqpassword=Public123

[32] "AOT Program Statistics: Recipients under Court Order."

reality, however, it is incredibly difficult to complete the AOT petition process from the community. 84% of AOT petitions in New York State are filed by a hospital while the subject of the petition is an inpatient with only 13% filed from the community, and the remaining 3% filed from correctional facilities.[33]

The process for obtaining AOT orders is long and involved, one of the reasons why they are not always achievable for those who could benefit from them. First, the petitioner must file a petition in the county court where the individual resides, including:

1. A formal statement of facts demonstrating that the person meets the criteria for AOT AND
2. An affidavit by a physician who has examined the individual within the last ten days.

Both the petition and the physician's sworn statement must demonstrate that the individual meets ALL of the following criteria for AOT orders. He or she must be:

1. 18 years of age or older;
2. Suffering from a mental illness;
3. Unlikely to survive safely in the community without supervision (based on a clinical determination);
4. Have a history of lack of compliance with mental illness treatment that has led to either:
    - Two psychiatric hospitalizations in the preceding 36 months OR
    - At least one act of violence towards self or others, or threats of serious harm to self or others, within the preceding 48 months;
5. Unlikely to voluntarily participate in a recommended outpatient treatment plan that would enable them to live safely in the community;
6. In need of outpatient treatment to prevent a relapse or deterioration likely to result in serious self-harm or harm to others;
7. Likely to benefit from AOT.[34]

In order to establish the need for court-ordered treatment, a petitioner typically also needs to provide medical records. If the individual does not consent to the release of their mental health records, the petitioner must obtain a subpoena for those records. Laypeople such as family and friends may have neither the means to provide such detailed records, nor the expertise to navigate this complex process.

Before a court hearing, a physician appointed by the county Director of Community Services (DCS) must prepare and submit a treatment plan to the court, with input (if desired) by the individual, their treating physician, and (with permission) a relative or close friend of the

[33] Swartz et al.

[34] "Assisted Outpatient Treatment (AOT)." *NYC Health*. Accessed November 16, 2021. https://www1.nyc.gov/site/doh/health/health-topics/assisted-outpatient-treatment.page.

individual. The treatment plan must include care coordination from programs like Health Home Plus, Assertive Community Treatment (ACT) and Intensive Mobile Treatment (IMT). It may or may not also include recommendations for: medication; group, individual, and/or family therapy; alcohol or substance abuse treatment; educational/vocational training; day programming; drug testing; and/or supervised living arrangements.

Once the petition is filed, the court schedules a hearing, at which the physician who provided the affidavit must testify. The subject of the petition has a right to legal representation, which can be provided by Mental Hygiene Legal Services, and may also testify or call witnesses on their own behalf. If different from the physician who provided the affidavit, the DCS-appointed physician must testify in court to explain the treatment plan and demonstrate that it is the least restrictive plan necessary to prevent self-harm or harm to others.[35]

NYS has very strong, patient-centered laws around mental health hospitalizations due to the history of abuses. Decisions about involuntary care should not be made lightly and should not be "easy" to obtain, but the current processes are incredibly burdensome for hospitals and all but impossible for community providers, let alone friends and family of individuals whose mental illness poses substantial risk of harm to self or others.

Under the current process, community providers, who have typically known their patients far longer and better than any attending hospital physicians, must rely on and defer to hospitals to file for AOT. New York City AOT program representatives explicitly tell community providers that the AOT petition process will be significantly longer and much less likely to succeed without the help of a hospital. There also seems to be a lack of shared understanding amongst hospitals, community clinicians, and homeless service providers about the thresholds for use of AOT, which furthers the divide between well-coordinated outpatient and inpatient care.

Hospitals are currently positioned with the best financial and logistical resources for filing petitions and applications according to the current process. They have direct access to a patient's medical records and physicians who will be needed to write an affidavit, testify, and work with the patient to come up with an AOT treatment plan. Hospitals are also most likely to have access to a patient while he or she is in inpatient treatment, and likely more stable and amenable to the filing process. That said, even hospitals face challenges in obtaining orders for treatment over objection and AOT. In the past year, only 88% of the 719 AOT petitions filed in New York City were granted – the second lowest of the five New York State Regions (Central New York, Hudson River, Long Island, and Western New York).[36]

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[35] "Assisted Outpatient Treatment (AOT)."

[36] "AOT Program Statistics: Petitions Filed." *New York State Office of Mental Health*. Accessed November 17, 2021. https://my.omh.ny.gov/analytics/saw.dll?Dashboard&PortalPath=%2Fshared%2FAOT%2F_portal%2FAOT%20Assisted%20Outpatient%20Treatment%20Reports&page=Program%20Statistics%20-%20Petitions%20Filed.

It should be noted that patients can qualify for a care coordination team like ACT or IMT on a voluntary basis, via the New York City Single Point of Access (SPOA) program for mental health referrals. As a homeless services provider, however, BronxWorks has found it incredibly difficult to get clients timely access to ACT/IMT services; it is not uncommon for referrals to be waitlisted for six to twelve months.

AOT Outcomes

The New York State Office of Mental Health (OMH) shows that 26% of AOT recipients statewide have had at least once episode of homelessness in their lifetime prior to AOT.[37] Given that the already complicated process of obtaining an AOT order is made harder when an individual does not have a stable housing situation, and/or family and friends to advocate their behalf, there is likely a much larger number of mentally ill homeless individuals who qualify for AOT than are reflected in the current numbers.

Mandated treatment must include care coordination from programs like Assertive Community Treatment (ACT) and Intensive Mobile Treatment (IMT), but can also include recommendations for medication, therapy, substance use treatment, educational/vocational training, and/or supervised living arrangements. The benefits of AOT for mentally ill individuals are well-documented. Recipient Outcome Summaries from the NYS OMH show a 63% reduction in reported episodes of homelessness for participants in the AOT program, a 66% reduction in hospitalizations, and a 73% reduction in incarceration.[38]

Per Table I, individuals with AOT orders have increased participation in medication services (184% increase), housing support services (238% increase), and alcohol and substance treatment services (257% increase). AOT recipients also show a significant reduction in "harmful behaviors," including substance use (29%-30% decrease), attempted suicide (57% decrease), property destruction (47% decrease), public disturbances (50% decrease), threats of physical violence (50% decrease), physical abuse/assault (47% decrease), and verbal assault (48% decrease). Recipients themselves also had reduced experiences of physical or sexual abuse (30% decrease).[39] This overwhelmingly positive data further documents the potential benefits of increased access to care coordination teams and AOT orders.

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[37] "AOT Recipient Outcomes—Significant Events: Homelessness." *New York State Office of Mental Health*. Accessed November 12, 2021.
https://my.omh.ny.gov/analytics/saw.dll?Dashboard&PortalPath=%2Fshared%2FAOT%2F_portal%2FAOT%20Assisted%20Outpatient%20Treatment%20Reports&page=Recipient%20Outcomes%20-%20Significant%20Events

[38] "AOT Recipient Outcomes Summary."

[39] "AOT Recipient Outcomes Summary."

Table 1[40]

Service	Prior to AOT	At 6 Month	% Increase After 6 Months	Most Recent Follow-Up	% Increase After Entire Duration
Medication (for psychiatric condition)	27%	82%	184%	78%	184%
Housing and housing support service	11%	40%	238%	38%	238%
Alcohol or substance abuse services	11%	39%	257%	38%	257%

Table 2[41]

Risk	Prior to AOT	First 6 Month Follow-Up	% Reduction After 6 Months	Most Recent Follow-Up	% Reduction After Entire Duration
Any Harmful Behavior	57%	46%	20%	39%	33%
Abuse Alcohol	26%	22%	17%	19%	30%
Abuse Drugs	25%	23%	10%	18%	29%
Attempted suicide	10%	6%	41%	5%	57%
Created a public disturbance	24%	15%	37%	12%	50%
Damaged or destroyed property	13%	8%	34%	7%	47%
Threatened physical violence	28%	17%	40%	14%	50%
Physically abused/assaulted others	13%	7%	42%	7%	47%
Verbally assaulted another person	30%	20%	34%	15%	48%
Victim of physical or sexual abuse	4%	3%	16%	3%	30%

[40] Table excerpted from "AOT Recipient Outcomes Summary."

[41] Table excerpted from "AOT Recipient Outcomes Summary."

According to a 2009 evaluation on the AOT program in New York State, AOT orders are primarily used to reduce hospital recidivism and improve treatment effectiveness post-hospitalization; three quarters of all AOT orders in New York State are implemented as part of a discharge plan for currently hospitalized patients. AOT could also be implemented, however, to prevent decompensation before a hospitalization becomes necessary.[42]

Limitations of Homeless Service and Community Care Providers

Statewide, the number of AOT participants under court order has increased from 3,161 in 2017 to 3,411 in 2021. In New York City, however, that number has declined from 1,610 in 2017 to 1,473 in 2021 – more than an 8% decrease.[43] This comes at a time when public concern about homelessness and, especially, homeless individuals who are mentally ill, is particularly high. Questions about homelessness were a feature of most mayoral debates in the 2021 democratic primary, particularly in response to a perceived increase in random assaults and incidents involving individuals suspected of being both homeless and mentally ill on New York City streets and subways.[44]

Amidst all of this, homeless service providers have experienced situations where New York City hospitals appear to avoid psychiatric admissions of severely mentally ill homeless individuals. A typical scenario is as follows:

1. Homeless service provider calls 911 for an involuntary removal by NYPD and EMS, after an incident where a client has posed a direct danger to themself or others.
2. Homeless service provider gives documentation of a client's psychiatric history to EMS.
3. Homeless service provider arranges for the client's community psychiatric provider to call the hospital and advocate for admission on the client's behalf.
4. Homeless service provider discovers that a client has been discharged less than 24 hours later when the client unexpectedly returns to shelter, without notification from the hospital

From speaking with other homeless service providers, ACT and IMT teams, and even the city's own Health Engagement Assessment Teams, this is not an uncommon occurrence. Even when individuals do have AOT orders or an ACT/IMT team, community providers need support from hospitals to coordinate admissions or discharge plans when a client is posing a danger to themself or others.

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[42] Swartz et al p. 18

[43] "AOT Program Statistics: Recipients under Court Order."

[44] Newman, Andy. "Candidates Differ over How to Address Homelessness and Mental Illness." *The New York Times,* online. June 17, 2021. https://www.nytimes.com/2021/06/16/nyregion/candidates-differ-over-how-to-address-homelessness-and-mental-illness.html.

BronxWorks recently experienced an incident with a hospital involving a client who *did* have an IMT team in place already. The homeless service provider coordinated with the client's IMT team and DHS officials to advocate for inpatient psychiatric care following multiple incidents where the client had threatened to take his own life and had caused bodily harm to others. The hospital, however, refused to admit this client, stating in an email that he "jeopardize[d] the safety of our staff and other patients." Rather than arrange for an appropriate transfer, the hospital instead discharged the client without a discharge plan.

In another instance, following multiple verbal and physical incidents in preceding days, a client was taken to the ED for suicidal ideation. This client asked to be admitted voluntarily because she felt she needed help. Homeless services staff and the client's psychiatrist called the hospital to advocate on her behalf, but the hospital ultimately discharged her from the ED without psychiatric admission. In explanation, they told the case manager over the phone that they "know" the client in question and had determined that her ideation was "not serious."

In yet another incident, BronxWorks was unable to get a shelter client with an SMI admitted to a psychiatric hospital for treatment, despite multiple attempts. Eventually, this client pushed a stranger in front of a NYC subway train, a situation nearly identical to the incident that led to the passage of Kendra's Law over 20 years ago – though in this case the stranger was, fortunately, not seriously hurt. The mentally ill individual is now standing trial for attempted murder and will likely be sentenced to lengthy time in prison – an outcome that could have been prevented, had he been able to obtain the mental healthcare he so desperately needed.

New York State has laws and procedures in place to help mentally ill individuals who pose a danger to themselves or others, but hospitals are essential parts of this continuum of care. New York City hospitals' neglect of duty-of-care and apparent refusal or inability to coordinate with community providers is leading to poor health outcomes and increased criminalization of mentally ill homeless New Yorkers.

Criminalization of Mental Illness and Homelessness

A combined study with the Treatment Advocacy Center and the National Sheriff's Association found that, nationwide, a seriously mentally ill individual is three times more likely to be incarcerated rather than hospitalized.[45] The probability varies slightly state by state and can be correlated based upon the money each state invests in mental health services. Those with higher mental health care expenditures, for instance, have higher rates of hospitalization and lower rates of incarceration. But in every state except North Dakota, there are significantly more mentally ill individuals in jails and prisons than there are in hospitals.[46]

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[45] Torrey et al.

[46] Torrey et al.

Mentally ill prisoners are more expensive for correctional systems, which must pay for psychiatric treatment, medication, and additional staffing. They are often incarcerated for longer amounts of time because of facility rule violations, or because they are waiting for a psychiatric hospital bed to become available. Data from NYC's Rikers Island shows that the average stay for all inmates is 42 days, but for mentally ill inmates it is 215 days. Mentally ill prisoners are also believed to have higher rates of recidivism; in LA County, for example, data shows that 90 percent of mentally ill inmates are repeat offenders.[47]

Most concerningly, mentally ill inmates are more vulnerable to abuse from corrections officers and other inmates. They are also more likely to commit suicide while incarcerated. 43% of detainees in New York City's jail system receive a mental illness diagnosis[48]; of that, about one third, or 16%, of the total jail population has a serious mental illness.[49]

The link between homelessness, mental illness, and incarceration is well-documented. Research from the department of justice shows that around 15% of incarcerated individuals experienced at least one episode of homelessness in the year prior to their incarceration. People who have been incarcerated have rates of homelessness almost seven times higher than the general public, and people who have been incarcerated more than once have over thirteen times higher rates of homelessness, when compared to those with no history of incarceration.[50]

There is limited data on the percentage of homeless individuals in New York City who have spent time in jail or prison, but it is generally accepted that at minimum, one quarter of individuals in the DHS system have a history of incarceration.[51]

If New York City hospitals are willing to work with homeless service and community care providers, they have the power to break the cycle of homelessness, incarceration, and emergency room visits for some of New York's most vulnerable mentally ill individuals. When hospitals neglect challenging and unprofitable patients, it is up to city officials to investigate, hold hospitals accountable to their duty of care, and ensure there is adequate staffing and resources to do so.

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[47] Torrey et al.

[48] Khurshid

[49] Ford et al.

[50] Couloute, Lucius. "Nowhere to Go: Homelessness among Formerly Incarcerated People." *The Prison Policy Initiative*. August 2018. https://www.prisonpolicy.org/reports/housing.html.

[51] Metraux, Stephen, and Dennis P. Culhane. "Recent Incarceration History Among a Sheltered Homeless Population." *Crime and Delinquency* 52, no. 3 (July 2006): 504–17.

Support and Connection Centers

Emergency and involuntary impatient admission standards require that an individual's untreated mental illness is imminently likely to result in serious physical harm to self or others.[52] In these situations, hospitals must fulfil their duty of care and admit patients in need. There are situations, however, where an individual may be experiencing a mental health crisis which does not meet the standards for substantial threat of harm, but which still require a higher level of care than can be provided in a non-emergency community care setting.

In 2019, New York City announced plans to open two "Support and Connection Centers" (also known as Crisis Diversion Centers or Crisis Stabilization Units) as an alternative to mental health-related ED visits or criminal justice interventions in these exact scenarios.[53] The centers are voluntary-participation facilities which offer short-term non-emergency services for mental health and substance use crises, including counseling, peer support, case management, referrals to long-term health and social care, medically supervised substance use withdrawal services, food, showers, laundry, and overnight shelter. Individuals can choose to stay and stabilize at the facility from a few hours up to 10 days, and staff assist them in crafting a discharge plan.[54]

Support and Connection Centers are intended to be a supportive place where police can bring individuals in mental health and substance-related crises that do not pose an imminent risk to self or others, and do not require emergency medical care or criminal justice involvement. They are an important intermediate option for individuals who need more support than traditional community care, but do not meet the thresholds for inpatient hospitalization. Similar programs have seen success in Los Angeles, San Antonio, and Dutchess County, New York.

In New York City, however, "Support and Connection Center" facilities have been woefully underutilized. The first facility opened in East Harlem in February 2020 but suspended in-person services from March to October 2020 because of the COVID 19 pandemic. The second center is expected to open in the Bronx early this year. From October 2020 to September 2021, the total reporting period available, only 177 people were brought to the East Harlem site for services; of these, just 89 stayed overnight.[55]

[52] "Mental Hygiene Law - Admissions Process." Accessed December 14, 2021. https://omh.ny.gov/omhweb/forensic/manual/html/mhl_admissions.htm.

[53] Mayor's Office of Community Mental Health. "Support and Connection Centers (Formerly Diversion Centers)." November 10, 2019. https://mentalhealth.cityofnewyork.us/program/support-and-connection-centers.

[54] "City Announces Opening of the East Harlem Support and Connection Center, With Bronx Center to Open Later - NYC Health." February 19, 2020. https://www1.nyc.gov/site/doh/about/press/pr2020/east-harlem-support-connection-center-opening.page.

[55] "Mayor's Office of Community Mental Health | Program Dashboard." Accessed December 14, 2021. https://mentalhealth.cityofnewyork.us/data/#/program/5eab7ff8e7d31e7a02b50ceb.

Best practice recommendations for crisis receiving centers state that individuals in crisis should be able to walk in to crisis centers to request service, be referred by crisis hotline operators and family members, and/or be transported by first responders.[56] New York City's centers, however, currently only accept referrals from the NYPD and the new B-HEARD (Behavioral Health Emergency Assistance Response Division) response team following mental health related 911 calls. Given the demand for mental health crisis services, particularly amongst homeless populations, city officials should amend the admissions process for Support and Connection Centers to allow, at minimum, referrals from clinicians in the community. Ideally, clients should be afforded the agency to access these services on their own. Expanded access would allow individuals in non-emergency crises to obtain care and would also reduce burdens on hospital emergency rooms.

Proposed Solutions:

City officials can take the following steps to address the challenges identified in the analysis above:

1. Establish standard policies and procedures, as well as a communication structure for hospitals and community care providers to:
    a. Obtain appropriate and expedient psychiatric admissions for clients with Serious Mental Illness (SMI), with significant input from community service providers who have day-to-day experience working with the individual
    b. Require notification to community clinicians upon admission from another source
    c. Develop a community care plan prior to discharge in collaboration with community service providers which should include, when appropriate, petitioning for an AOT order or expediting an IMT/ACT team application
2. Establish a simple and direct process for homeless service and community care providers to report inappropriate discharges, admission refusals, and EMTALA (Emergency Medical Treatment and Labor Act) violations to city officials.
    a. Establish an independent panel of community care providers and hospital staff to investigate these violations and issue appropriate disciplinary actions for facilities involved in negligence
3. Ensure that adequate resources are available for hospitals to treat patients who need care, including:
    a. Institute minimum staffing requirements to ensure the safety of patients and employees
    b. Institute minimum staffing requirements to coordinate patient transfers to appropriate inpatient psychiatric facilities or crisis stabilization centers
    c. Institute higher minimums for the number of inpatient psychiatric beds that must be available across New York City hospitals

[56] "National Guidelines for Behavioral Health Crisis Care - A Best Practice Toolkit." Substance Abuse and Mental Health Services Administration, 2020.

    d. Create dedicated units for individuals who need longer periods of inpatient care than the typical 4-6 day stay, but who do not meet standards for long-term institutional stays
    e. Lobby state government to amend Medicaid reimbursement structures for inpatient psychiatric care
    f. Lobby state and federal government to raise minimums for the number of inpatient psychiatric beds that must be available state and nationwide
4. Assess potential streamlining of the AOT petition process to reduce reliance on hospitals and allow community providers more agency to advocate for their patients
5. Invest in and expand access to non-emergency crisis resources such as crisis diversion centers
    a. Allow walk-ins and community referrals to NYC Support and Connection Centers
    b. Expand the number of centers to at least one per borough
6. Maintain steady funding and resources for outpatient and community care
    a. Increase the number of IMT/ACT teams and reduce wait times to obtain a team

Conclusion

Homeless clients receive the best care when hospitals, homeless services providers, and community mental health providers collaborate with one another on patient admissions, discharges, and care plans. Collaboration should be the standard practice, rather than the exception. For clients with AOT orders and ACT/IMT teams already in place, it is even more essential that hospitals work with outpatient providers to review the decompensation that led to another hospitalization and amend the treatment plan.

Not every hospital is equipped to deal with mentally ill individuals who pose a direct and active danger to themselves or others, but hospitals should arrange for an appropriate transfer when faced with a patient who is more than a facility can manage. When this does not occur, we need a simple and direct process for homeless service and community care providers to report inappropriate discharges, admission refusals, and EMTALA violations to city officials.

The pressures on hospital emergency departments and the limited number of inpatient psychiatric facilities are immense. City officials must take action to ensure they have the staffing and resources to manage vulnerable and at-risk patients. If even hospitals are unable to adequately treat individuals who pose substantial threat of harm to self or others because of mental illness, these individuals far too often end up in prison.

NYS has very strong, patient-centered laws around mental health hospitalizations due to the history of abuses. Decisions about involuntary care should not be made lightly and should not be “easy” to obtain. But we must ensure that there is a consensus in understanding amongst hospitals, community clinicians, and homeless service providers about the thresholds for use of current policies and procedures. It is also worth evaluating their effectiveness and ways they could be streamlined and improved to both reduce harm and ensure patients receive necessary care.

Crisis diversion and stabilization centers are well-established as effective intermediates between inpatient and community care during moments of crisis, but NYC Support and Connection Centers are currently inaccessible and vastly underutilized in New York City.[57] City officials should amend referral and admissions processes for these highly effective alternatives to inpatient care and ensure they can be accessed by community clinicians to fill the gap in mental health services, when appropriate.

Mental health outreach and homeless outreach teams provide an essential piece of the care continuum, but are rendered less effective when they are unable to access inpatient care, care coordination teams, and/or crisis diversion centers for the clients they know and serve.

Jails and prison should not be the de facto solutions for severely mentally ill individuals who pose a substantial threat of harm to self or others and aren't able to access care. The City must work with hospitals and community providers to collaborate on compassionate and effective models of care.

[57] Saxon, Verletta, Dhrubodhi Mukherjee, and Deborah Thomas. "Behavioral Health Crisis Stabilization Centers: A New Normal." *Journal of Mental Health & Clinical Psychology* 2, no. 3 (June 8, 2018). https://www.mentalhealthjournal.org/articles/behavioral-health-crisis-stabilization-centers-a-new-normal.html.

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