



Testimony of

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At the Oversight Hearing: Exploring the Relationship  
Between Mental Health & Homelessness

The Committee on Mental Health, Mental Retardation,  
Alcoholism, Drug Abuse and Disability Services

Hon. G. Oliver Koppell, Chair

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## **INTRODUCTION**

Chairman Koppell, distinguished members of the Committee, thank you for allowing us the opportunity to testify before you today on the relationship between homelessness and mental illness. My name is Michael Polenberg, and I am the Director of Policy & Advocacy for the Coalition of Voluntary Mental Health Agencies, the trade association and umbrella advocacy organization of New York's mental health community, representing over 115 non-profit community-based mental health agencies in New York City and surrounding areas. Our members constitute a broad cross section of service providers – all sizes from very small to very large; treatment and rehabilitation-oriented; outpatient and residential; focused on linguistically and culturally specific populations and on many special-needs – serving more than 350,000 individuals in the five boroughs of New York City and its environs.

We are delighted that this Committee has chosen to hold an oversight hearing on the relationship between homelessness and mental illness. Much has been done in this arena over the last few years. A third New York/New York agreement has been signed that will fund 9,000 units of supportive housing, many of which will be dedicated to mentally ill individuals and their families. New collaborations on outreach between the Department of Homeless Services and the Division of Mental Hygiene have been forged that will hopefully produce meaningful and lasting results. In the last three years, the Governor has funded significant rate increases for two housing programs for homeless mental health consumers; Community Residences and supported housing.

But one only needs to walk through Penn Station or ride the subways to know that our work is far from finished. Despite the recent investments and collaborations, far too many New Yorkers living with psychiatric disabilities find themselves shuttling between the shelters, the jails, emergency rooms and the streets. Our testimony today will focus on the successful role the community based mental health sector has played in addressing homelessness, as well as the ongoing need to strengthen and fortify the sector to ensure prompt access to appropriate housing and treatment. We will also discuss the role that public benefits, particularly Medicaid, plays in helping individuals with mental illness receive much-needed care. Finally, we will offer a few suggestions to help ensure that goals of the most recent New York/New York housing agreement are enacted in a way that benefits all New Yorkers.

## **HOMELESSNESS**

Beginning in the mid 1950's, the development of new psychotropic medication and therapy techniques allowed scores of people living with mental illness to leave inpatient hospital settings and enter community-based settings. In 1955, nearly 560,000 mental health consumers lived in State psychiatric hospitals across the country. Today, that number has dropped to just 110,000 people. Here in New York State, the inpatient psychiatric hospital census dropped from 93,000 in 1955 to just over 5,000 people today.

Unfortunately, the mental health dollars have not always followed the client. Most savings associated with the closing of hospital beds were simply returned to the State's general fund. The development of the Community Support Program in the late

1970's was instrumental in funding some mental health services, but significant gaps remained, particularly as far as housing was concerned. Accordingly, consumers were left with few options. Some managed to find arrangements. They reunited with family members, or obtained meager housing in the City's commercial SROs. Others fared more poorly, particularly after massive federal cutbacks in affordable housing and public entitlements took place in the 1980s. Those consumers who had found modest but affordable lodging in commercial SRO's now increasingly found themselves victims of gentrification and more restrictive public assistance rules. By midway through that decade, New Yorkers began noticing larger numbers of street-bound homeless men and women, seeking refuge in transit hubs, parks, and bank vestibules.

The problem was compounded by the fact that supportive community services had simply not been made available to large numbers of people being discharged from psychiatric institutions. In the absence of viable treatment programs in the community, many of the homeless mentally ill turned to street drugs for symptom relief, further compounding the crisis. Research over the last fifteen years has demonstrated that supportive services and integrated substance abuse services are equally critical to recovery as the housing unit itself.

## **SUPPORTIVE HOUSING**

The recent New York/New York III agreement signed in November by Mayor Bloomberg and Governor Pataki to create 9,000 units of supportive housing over the next ten years is remarkable not only for its scope, but also for how far government has come in recognizing the value of the community mental health sector, and supportive

housing in particular, as a cost-effective alternative to shelters, jails, hospitals and the streets for the homeless mentally ill.

Twenty-five years ago, the St. Francis Residence opened its doors on East 24<sup>th</sup> Street as the City's first single-site supportive housing project. Combining a rental subsidy with social services provided by DMH and HRA, this project moved scores of homeless New Yorkers living with mental illness out of shelters and dilapidated SROs and into permanent housing. More projects were developed in the following years – some serving only the mentally ill, some serving mixed populations – and a new supportive housing movement was born.

In 1990, the City and the State entered into the first New York/New York agreement to fund over 3,300 units of housing for the homeless mentally ill. As these units were brought on line, the City's shelter census dipped noticeably, only to rise several years later as the housing units quickly filled up. A second New York/New York agreement later that decade produced another 1,500 housing units for this population. While still investing heavily in shelters, both the City and the State were beginning to acknowledge that an adequately funded community-based mental health sector, including licensed and non-licensed housing, could offer enriched services at a fraction of the cost of other settings like shelters, jails and in-patient psychiatric hospital beds. Furthermore, individuals stabilized in permanent housing were more likely to access additional services such as clinic treatment or continuing day treatment programs.

We should point out that we are very concerned with a new proposal from the City to backfill vacant NY/NY I & II units with the chronically homeless, or those defined as having been continuously homeless for at least one year. The City's proposal is certainly well-intentioned; housing should be prioritized for those most in need. But we are very skeptical of the absolute requirement to place chronically homeless clients in existing single site or especially scatter-site apartments, particularly in places where providers have entered into commitments to landlords and communities about the level of services that will be provided for unstable and mentally ill clients with a variety of co-morbid conditions. The notion of "housing first" and services later understates and misunderstands the clinical complexity of the problems presented by many chronically homeless mentally ill clients, a number of whom also present with a substance abuse disorder.

Inflation has weakened the service dollar for providers, who are spending an increasing share of their funding on housing-related expenses. Housing providers require an enhanced rate to more adequately respond to the needs of a population that is proportionately more likely to include individuals who are actively abusing substances, not complying with medication regimens, and unable to maintain public benefits, including Medicaid. One suggestion would be the addition of a dedicated ACT or case management team assigned to congregate and scattered site housing to work with those clients most in need. We ask the Division to work with its partners at DHS and HRA to ensure that the clinical needs of this complex population are addressed in an enriched service environment.

## **REINVESTMENT**

A major shift in how government thought about the community mental health sector came in 1993 with the passing of the Community Mental Health Reinvestment Act. As the census in the State psychiatric hospitals continued to drop, it became apparent that some of the hospitals themselves were becoming superfluous. Advocates, led by the Coalition, hammered out an agreement with the legislature and former Governor Cuomo that would re-invest a portion of the savings associated with a downsized or closed hospital into the non-profit community-based sector. Many of the programs currently contracted out by the City's Division of Mental Hygiene were initially created using reinvestment dollars, including outreach programs and drop-in centers for the homeless mentally ill.

While this funding mechanism has been enormously helpful in creating a more effective and adequately funded system of care for mental health consumers, the proverbial well is running dry. The State needs to maintain a core number of its psychiatric hospitals to help those in crisis and those most in need, and it is unlikely that there will be enough savings from future bed closings to address the community mental health sector's growing needs. Furthermore, the State has converted a sizeable portion of reinvestment dollars into Medicaid, thereby diluting the pool even further. A new dedicated source of revenue will need to be created to help ensure the continued vitality of the community mental health sector.

## **MEDICAID**

We would like to briefly touch upon the role of Medicaid in the community mental health sector and the homeless individuals it serves. Over the past decade, the State and the City have sought to shift the cost of mental health services to the Federal government by “Medicaid-ing” a range of programs, including clinics, continuing day treatment, ACT, case management and others. The State is right now putting the final touches on a new Medicaid-funded license to integrate treatment and rehabilitation programs called PROS. While from a budgetary standpoint this may appear to help preserve programs’ gross funding in tight fiscal years, it also has the effect of limiting options for non-Medicaid eligible consumers.

Indeed, many of our member agencies offer services and programs to the “working poor” and to immigrants – populations that do not qualify for Medicaid under current rules. And although eligibility in and of itself is not generally a pre-requisite for a homeless person to access non-licensed housing, Medicaid is critical for helping to pay for psychotropic medication and ongoing mental health treatment while the consumer is housed.

Meanwhile, at all levels of government there is growing movement to sharply reduce the Medicaid burden on taxpayers. The President signed into law the Deficit Reduction Act which cuts \$4.8 billion in Medicaid spending over the next five years. The President’s new budget proposal looks to make even further reductions. Here in New York, the Governor’s Executive Budget includes a range of Medicaid cuts (even as his budget office continues to transfer costs to the Federal government.) It is becoming

very apparent that relying too heavily on Medicaid to be the primary funding source for the community mental health sector will leave it increasingly vulnerable to funding cuts at every level.

### **RECOMMENDATIONS: COST OF LIVING ADJUSTMENT**

Providers who contract with the City and/or the State to provide housing for needy and vulnerable people are, in effect, doing the work of government. They offer a wide range of housing and services for consumers from a variety of backgrounds, in neighborhoods in every corner of the city. But many of these programs receive the same reimbursement dollars today that they did five, ten, or even fifteen years ago. As a result, providers have no mechanism to account for inflationary increases such as fuel and energy, rent and salaries.

The Governor's Executive Budget proposal for SFY 2006-2007 includes a 2.5% increase for each of the next three years for virtually all non-trended mental health programs. In proposing a multi-year COLA, the Governor's office acknowledged that inflation erodes program dollars and therefore the scope and depth of services, and that annual adjustments are necessary in order to maintain the quality and reach of those programs. We ask the City to add a mental hygiene COLA to the Mayor's Fiscal 2007 Executive Budget proposal that will, at the very least, match the increase proposed by the Governor.

## **RECOMMENDATIONS: ENHANCED RATE FOR CHRONICALLY HOMELESS**

As mentioned earlier in our testimony, we urge the City to enhance the rate for providers who will be required to backfill vacant NY/NY I & II units with the chronically homeless. Given the likelihood that many of these individuals are not medication-compliant (if they have Medicaid at all), suffer from co-occurring substance abuse disorders, and in some cases will be coming directly from the streets, the City should take immediate steps to ensure that providers have the financial resources necessary to ensure a service-rich environment for high need individuals.

## **RECOMMENDATIONS: TECHNICAL ASSISTANCE**

The NY/NY III agreement extends beyond mental health to include a number of other populations vulnerable to homelessness. This includes adolescents aging out of foster care; chronically homeless families; and individuals with substance abuse disorders. In some cases new models will need to be developed that will be appropriate to the unique needs of the particular population. We urge the City to consider funding technical assistance for supportive housing providers to ensure that the proposed models are designed in such a way as to be the most beneficial to these new groups.

## **RECOMMENDATIONS: SITING ISSUES**

Another issues related to NY/NY III concerns the obstacles providers face in trying to site housing developments. Since 70% of these units will be new development, it is important that providers are able to locate sites that serve the needs of their consumers as well as the communities in which they're located. Unfortunately, there sometimes exists a predisposed opposition to low-income housing, particularly for

mental health consumers, even as most communities favor the creation of housing over shelters. The City Council has long championed the development of affordable housing, particularly for people living with disabilities. We look to the Council, both collectively and on an individual basis, to work with both providers and community boards to help broker agreements on siting new units as part of the NY/NY III agreement.

Thank you again for inviting us here today, and I'd be happy to take any questions you might have.