

**Testimony of Daniel Tietz**

**The New York City Department of Social Services | Human Resources Administration**

**New York City Council General Welfare and Mental Health Committees**

**Oversight Hearing Part 2 – Behavioral Health Services in the DHS Shelter System**

**November 21, 2016**

Good morning, Chairman Levin and Chairman Cohen, and distinguished members of the General Welfare and Mental Health Committees. Thank you for inviting us to appear before you today to discuss behavioral health services in the DHS shelter system. My name is Daniel Tietz and I am the Chief Special Services Officer for the New York City Human Resources Administration (HRA) in the Department of Social Services, which also includes the Department of Homeless Services (DHS). Since the start of the 90-day review of DHS that was conducted earlier this year, I have assisted in the oversight of program services at DHS. I am joined today by my colleague, Fabienne Laraque, the DHS Medical Director who started in early September after a distinguished career at DOHMH.

From the start, this Administration has made unprecedented investments to address the very serious challenges faced by low-income New Yorkers, particularly the most vulnerable New Yorkers, many of whom are served by DSS. Notable among these challenges are the many problems that have built-up over more than two decades and which tend to drive the DHS shelter census higher: insufficient behavioral health programs, justice system-involved individuals who are returning to New York City from prison, the loss of relatively inexpensive Single Room Occupancy (SRO) housing units, and a limited supply of available supportive and low-rent housing across the City. Taken together with long-term under-investments in truly affordable housing and flat incomes for hard-working families it becomes clear why one of the Administration's chief priorities has been reducing income inequality and leveling the playing field for all New Yorkers.

From its inception, this Administration has recognized and directly addressed these challenges through multiple historic investments to break the trajectory of homelessness, which has increased 115% since 1994, and exponentially from 2011 into 2014 when there were no rental assistance programs in place to address homelessness after the Advantage program was ended by the City and State.

- Beginning in late 2014, the Administration announced the creation of the Living in Communities (LINC) rental subsidies and since has expanded the availability of **rental**

**assistance** to support New Yorkers who qualify for assistance in order to remain stably housed.

- In June 2015, the Administration created the **Three-Quarter Housing Task Force**, bringing together representatives across city agencies to address a long-ignored problem thereby shining a light on an unregulated segment of the low-income housing market whose operators prey on New Yorkers in need of services and support as they transition to independence and self-sufficiency.
- Almost exactly one year ago today, Mayor de Blasio made a historic announcement concerning **Supportive Housing**, investing in 15,000 City-funded units over the next 15 years with the first 500 to be awarded shortly. We know from evidence-based research that supportive housing programs help reduce the use of shelters, hospitals, and psychiatric centers, reduce chronic homelessness, and improve stability.
- In December of 2015, prior to the completion of the 90-day review, the Mayor announced **HOME-STAT (Homeless Outreach & Mobile Engagement Street Action Team)**, a first-of-its-kind in the nation response to addressing street homelessness, and by April, the program was fully operational.
- **Safe Haven Beds** are an essential tool in assisting outreach workers in bringing our street homeless off the streets and into services. These individuals are the most vulnerable and hard to reach homeless New Yorkers and require ongoing and lower threshold engagement. To date, the City has opened 225 Safe Haven beds increasing the total to 752 beds, with more to come. There are also 357 stabilization beds to help bring New Yorkers in from the streets.
- **Cluster take-down**: to date, the City has discontinued the use of 250 cluster units and identified another 295 to be closed soon. This 16-year approach of removing affordable apartments from the housing stock and using them as shelter subjected families to fractured social services, challenges on their path towards independent living, and led to disrupted communities.
- **ThriveNYC**, launched earlier this year, is an extraordinary \$850 million investment over the next four years aimed at transforming the way we address the mental health needs of New Yorkers. This initiative is not only aimed at homeless New Yorkers, but all City residents who struggle with mental illness or are affected by a loved one's experience.

No New Yorker should suffer homelessness, and no one with a mental health problem should become homeless because of such an illness. Unfortunately, many people with behavioral health needs become homeless because it affects their ability to maintain employment, housing, or healthy relationships. To get at the root of this problem, we have embarked on a mission to transform the way we address mental health needs in New York City.

ThriveNYC is an action plan to change the way our city thinks about mental health and substance use disorders, and the way the City delivers services. Through ThriveNYC, we have increased the behavioral health workforce, developed innovative, cross-agency program models, and expanded crisis services for all New Yorkers.

It is important to acknowledge that no one became homeless overnight because of an illness. For homeless individuals with serious mental illness, there were numerous points in their life when they were not able to get the help they needed, when the system broke down. No illness should result in homelessness and, therefore, everyone needs a system where care is accessible.

Each of these actions taken alone is important, but together they represent a commitment by this Administration to tackle the very difficult challenges faced by low-income and working-class New Yorkers and that have received far too little attention for far too many years. Likewise, it will take time for our solutions to have a full and lasting impact and we will need the help and support of all, including this Council and our state and federal partners.

In my testimony today, I will provide a summary overview of the DHS system – which provides temporary and transitional housing, and serves as a place of last resort for those in need of shelter. I will focus much of my testimony on updating the committees on the progress of relevant and substantial reforms stemming from the completion of the 90-day review of the homeless services system in New York City. I will close with a more specific overview of the programs and services for families with children, as well as for single adults and adult families, to address clients' behavioral health needs while in shelter and the associated outcomes.

Last week, in Part 1 of this hearing, I provided some context and noted several ways in which HRA and DHS work closely to serve our shared constituents, taking a prevention-first approach. To summarize:

- Homebase, which had been administered by DHS has been moved to HRA.
- Over the past two years, the new rental assistance programs and other permanent housing efforts have enabled 47,810 children and adults in 17,094 households to avert entry into or to move from DHS and HRA shelters.
- January 2014 through June 2016, about 131,000 households – including approximately 390,000 people – received emergency rental assistance to help them stay in their homes, averaging about \$3,600 per case, which is much less than the \$41,000 it costs each year to shelter a family.
- This Administration has increased funding for legal services to prevent evictions, harassment, and homelessness 10-fold, from \$6.4 million in FY2013 to \$63.8 million in FY17 when the program is fully implemented.

- There has been a 24% decrease in evictions by City marshals over the past two years and an increase in legal representation of tenants in Housing Court from 1% as reported by the State Office of Court Administration for 2013 to 27% this year.

As was noted last week, and is worth repeating, those most at risk of homelessness are affected by high rates of poverty, family conflict and domestic violence, as well as poor health, including high rates of chronic disease and behavioral health diagnoses, coupled with low access to care. At DHS intake points, clients arrive with a host of complex and interrelated challenges, but have one thing in common: a lack of safe and affordable permanent housing. It is both our legal and moral obligation to shelter those New Yorkers who are found to be eligible for and in need of shelter.

As of November 19, 2016, DHS is sheltering 60,318 individuals, including:

- 23,657 children
- 36,661 adults

These individuals and families are housed across DHS's system of facilities for single adults, adult families with no minor children, and families with minor children utilizing shelters, cluster units, and commercial hotels. Among the facilities that constitute the DHS portfolio, 47 single adult shelters and 23 families with children shelters have access to on-site health care. We also operate a number of specialized shelters, including 27 mental health shelters; nine substance use disorder shelters; plus 14 safe havens and five drop-in centers.

I refer the committees to my testimony of November 17, 2016 in regards to the shelter intake process and the medical and behavioral health screenings that take place at the front door of shelter.

I will now describe details of the ongoing reforms most relevant to this hearing that were identified as part of the 90-day review of homeless services and which have been implemented since the announcement of the review.

## **REFORMS**

1. **Target services and rental assistance for clients with mental health needs cycling between jail and homelessness:** City rental assistance will be strategically targeted to identified at-risk clients with mental health needs cycling between Rikers Island and DHS shelters. DHS is working on this initiative with MOCJ and we look forward to continuing to update the Council on our progress in addressing the needs of these clients.

- 2. Fully launch HOME-STAT to address street homelessness:** HOME-STAT is a first-of-its-kind approach to allow us to better understand and address the City's street homeless population. This initiative partners existing homeless response and prevention programs with a series of new innovations designed to better identify, engage, and transition homeless New Yorkers from the streets to low threshold engagement and support services, as well as permanent housing.

This reform initiative began prior to the completion of the 90-day review and fully operational in April of this year. This innovative program is the most comprehensive street homelessness outreach effort ever deployed in a major American city. HOME-STAT innovates by partnering homeless response/prevention programs and by using modern technology such a mobile application and 311 services to more accurately identify, engage, and transition homeless New Yorkers from the streets to services. Additionally, by conducting more frequent, quarterly counts, the last having been completed in the overnight hours of November 6, 2016, we are able to more closely track our efforts and evaluate our approaches to better tailor solutions to the visible problem of street homelessness.

With nearly 500 workers to help transition homeless individuals from the streets and into shelters, HOME-STAT is enabling the City to better address the needs of New Yorkers who are living on the streets. Canvassing conducted by the Mayor's Office of Operations has increased our ability to identify street homeless individuals from Canal Street to 145th Street and in other hot spots, and deploy outreach resources where they are needed most.

With HOME-STAT the contracted homeless outreach staff grew from 195 to approximately 385. Additionally, the NYPD redeployed 40 officers to its 70-officer Homeless Outreach Unit to respond to calls concerning street homeless persons, encampments, large hot spots and those individuals experiencing emotional disturbances or exhibiting erratic behavior.

Additionally, we enhanced funding for additional safe haven beds, and three more drop-in centers.

Drop-in centers provide a low-threshold alternative to traditional shelter for street homeless individuals and offer temporary respite where individuals can shower, eat a meal, see a doctor, and rest. There is on-site case management and housing placement services, as well as a limited number of off-site overnight respite beds.

The City announced a new \$8.5 million annual commitment to double the number of drop-in centers it currently operates. DHS will open three new drop-in centers and fund the current HUD-funded drop-in center in the Bronx, which is operated by BronxWorks, as HUD looks to reinvest those dollars in permanent housing. These four locations will be added to

the four existing City-funded centers: two in Manhattan, one in Staten Island and one in Brooklyn. The new centers will open in Manhattan, Brooklyn and Queens, serving approximately 75 clients each at any given time.

These tools are important in creating a low-threshold option to serve as an initial link to DHS programs and services as part of our intensive effort to persuade street homeless individuals to engage in services and ultimately accept permanent housing.

All of these initiatives to address street homelessness recognize that the pathway to the streets was not linear for these individuals and the path from the street likely won't be either. Therefore, a one-size-fits-all approach is unlikely to work. All HOME-STAT agencies play a role in this effort, including DHS, HRA, NYPD, other health, housing and human services providers.

DHS would also like to remind caring New Yorkers to help us help homeless New Yorkers by calling 311 if they see a homeless person on the street or in the subway so that an outreach team can be deployed. This can also be done by accessing the 311 website.

- 3. Enhance tools for outreach teams to bring people in from the streets:** The City will increase safe haven beds, increase the number of drop-in centers, and develop 15,000 units of supportive housing to provide essential tools to address street homelessness.

As described earlier in my testimony, progress on these reforms is well underway and we continue to ask the City Council to partner with DHS in order to site not only safe haven beds, borough-specific drop-in centers, and supportive housing, but also necessary purpose-built shelters for families with minor children, adult families, and single adults. Homelessness is a citywide problem and we each have a role to play in securing effective solutions. As such, good, purpose-built shelter ensures greater impact and better helps families to more quickly transition to permanent housing and independence.

- 4. Targeting services for emerging new trends in the single adult population (persons 50 or older and 18 to 24):** More effective targeting will promote our prevention and rehousing efforts. For example, in partnership with Council Member Ritchie Torres, we announced last Friday the first-of-its-kind shelter in the DHS system targeting young adult LGBTQI homeless New Yorkers. DHS's ability to respond to emerging trends in the single adult population allow us to better serve our clients and more quickly move them to independence through targeted supports.

Additionally, DYCD is expanding its runaway and homeless youth beds and working closely with DHS and DSS to improve coordination and services for youth who come to DHS shelters.

I should also note that for older adults, in partnership with HPD and DFTA, HRA recently released a senior affordable housing concept paper. The concept paper focused on receiving comments about the most appropriate services to support seniors living in independent housing. An RFP will soon follow.

5. **Implement a more effective aftercare program:** Using the critical time intervention as a model, the City will enhance aftercare services for rehoused clients.

DSS released a concept paper in late October with the goal of expanding and re-aligning services at Homebase such that HRA staff can provide additional on-site processing and triage for HRA benefits, including public assistance and rental assistance, and Homebase not-for-profit staff can expand their case management services to include landlord and family mediation, educational advancement, employment, and financial literacy services. Additionally, we intend to provide enhanced community support services for residents receiving rental assistance to help ensure that they do not return to shelter and will remain housed in the community. Comments on the concept paper are due December 14, 2016 and an RFP will be issued shortly thereafter.

6. **Provide assistance to obtain federal disability benefits:** The City will dedicate services to focus on enrolling shelter residents on SSI/SSD to increase income and promote rehousing.

We are expanding legal services to help clients obtain disability benefits and we continue to focus on ensuring that New Yorkers who are eligible for benefits and services are linked to the same. DSS is actively exploring ways in which we can reduce barriers to access benefits and promptly link eligible clients to benefits. We are making critical improvements to ACCESS NYC, the city's one-stop, online benefits tool that screens individuals for over 30 benefits as well as an online portal so that a client can obtain information about their benefits in real time.

I will now focus on several core programs at DHS that serve clients with behavioral health diagnoses.

## **SERVICES ACROSS THE DHS SYSTEM**

### **Assessment and Screening for FWC**

As I testified on November 17, 2016, many families have existing medical and mental health care providers upon arrival at the Prevention Assistance and Temporary Housing (PATH) center, and thus not all families are referred to the on-site medical provider for comprehensive assessments. At PATH, each woman of childbearing age in the family is asked about pregnancy, the presence of an infant under four months of age, any hospitalization in the past month, any

acute medical needs, or the presence of a communicable disease. If any of these are present, the family is referred to The Floating Hospital, which is the on-site clinical provider. In addition, families self-reporting or observed to be facing mental health or substance use challenges are referred to DHS Resource Room Social Workers for further assessment. As part of our reform process, the DHS Medical Director's Office, in collaboration with HRA and DOHMH, is reviewing which questions families are asked in order to best address immediate medical and behavioral health needs in the intake process; setting standards for behavioral health services at intake points; crafting oversight tools; and implementing the oversight and evaluation processes.

### **Completion of Mental Health Assessment by Resource Room and The Floating Hospital**

Resource Room Social Workers complete mental health and substance use assessments in the DHS CARES system, including a history of symptoms and treatment and a risk assessment to determine orientation to time, place, and person; the potential presence of auditory and/or visual hallucinations; and any intent and/or plan to harm self or others. Assessment findings determine whether or not a call will be placed to 911 for EMS assistance and possible hospitalization. The emergency protocol, including calling 911 or presenting at the closest emergency room in the event of a psychiatric emergency, is reviewed with families. Available community-based services are also discussed with presenting families, including 1-800-NYCWELL.

Families identified with behavioral health needs not currently receiving treatment services are scheduled to meet with The Floating Hospital's psychiatrist who is stationed at PATH on Wednesdays from 10am to 6pm. The psychiatrist completes a comprehensive mental health evaluation (which is maintained in The Floating Hospital's electronic medical record). Families identified with mental health or substance use concerns that are currently receiving treatment are also given the opportunity to present supporting documentation from their treating clinician. The findings of these evaluations are reviewed by a Social Work Supervisor or Manager in conjunction with the prior or preliminary shelter eligibility determination with recommendations for final eligibility made after full consideration of the client's behavioral health needs.

If service needs are identified and services are not in place, the Resource Room Social Worker will discuss available options with the family and will provide support during their conditional stay, ensuring shelter staff are aware of the presenting issues and that necessary services are maintained or commenced.

Within the FWC system, the Clinical Services Unit launched in the winter of 2015 to address the particular needs of families and consists of a team of social workers who work across the FWC shelter system; please reference my November 17 testimony for additional detail.

## **Social Worker in Shelter - Demonstration Project**

In order to improve access to mental health services in FWC shelters, to improve family functioning, and to assist families with children in shelter as they navigate multiple systems and cope with the stressors and anxiety that are induced by homelessness, DHS is developing a plan to place 368 Licensed Masters' of Social Work staff in shelters for families with children. These LMSWs would serve as Client Care Coordinators.

DHS and DSS are working with State OTDA on approval of the demonstration project plan and budget such that the new Client Care Coordinator positions as part of the standard FWC budget. This will facilitate the rollout of the plan and ensure that shelter providers are able to expeditiously hire these LMSWs.

Through the use of these LMSW Client Care Coordinators, DHS will vastly enhance the delivery and coordination of mental health and related services to FWC in shelter, promote and model best practices for shelter social services and case management staff, improve linkages to mental health and community-based services, increase the ability of shelter social service staff to address mental health needs in a culturally and linguistically sensitive manner that incorporates strength-based, family-driven, and youth/child-guided care, and strengthen overall permanency outcomes for families with children in shelter.

## **Adults**

### **Psychiatric Evaluation at Assessment Shelters**

After intake, all adults admitted to the shelter system are sent to an assessment shelter where providers conduct a comprehensive assessment including history and physical, brief psychiatric assessment, and substance use assessment. The brief psychiatric assessment includes any presenting complaint, history of present illness, past psychiatric history, substance use history, medications, family and social history, and a full mental status examination. The assessment is completed within five and ten days of the client's arrival. This assessment is used to direct new entrants into the DHS system toward either a general or mental health or substance use shelter. These shelters provide specialized services on-site as well as linkage to an array of outpatient mental health services, as described below.

**Assisted Outpatient Treatment (AOT)**, in 1999 New York State enacted legislation that allows for mandated outpatient treatment by court order for persons with mental illness who are unable or unwilling to follow clinical guidance and treatment. This service, call Assisted

Outpatient Treatment or AOT, mandates mental health care for a period of up to six months, which can be extended once.

Whether after an AOT order or voluntarily, the following outpatient services are available to DHS clients with mental health issues.

Care Coordination:

A specially trained individual or team that helps clients better understand and manage their conditions, works with clients to create a plan of care that meets their physical, mental health and social service needs and assists the client in finding the services and programs that are right for their needs.

Assertive Community Treatment (ACT):

ACT is an evidence-based practice model that provides treatment, rehabilitation and support to individuals diagnosed with a severe mental illness and whose needs have not been well met by more traditional mental health services. The ACT team provides services that are tailored to each client's specific needs. ACT teams are multi-disciplinary and include psychiatry, nursing, psychology, social work, substance use counseling, and vocational rehabilitation. Team members collaborate to deliver integrated services to the client. Specialized ACT teams are being trained to reach and serve people who are chronically homeless.

Intensive Mobile Treatment (IMT):

IMT is a specialized team that provides intensive and non-billable treatment in settings that are convenient to clients who may be unstable. The teams are designed to keep clients in treatment, even if they are in an unstable situation, such as cycling from jail to street and shelter or face housing instability.

Co-response Teams:

The co-response teams are specially trained NYPD officers with embedded DOHMH clinicians that can more effectively respond to and triage individuals a serious mental illness and about whom we have great concern regarding potential violent behavior.

DHS and DOHMH collaborate to identify AOT clients in DHS facilities via a monthly data match. Each shelter operator is alerted to individuals with AOT orders residing in shelter and efforts are made to transfer AOT clients to mental health shelters, if necessary, to better ensure their continued connection to mental health treatment providers, and to more quickly place them in appropriate permanent housing. In addition, contracted clinical providers may refer to or request AOT services for their clients who meet the criteria.

In CY15 there were 239 individuals with AOT orders in DHS shelter.

**Mobile Crisis Teams** are an interdisciplinary team of mental health professionals, including nurses, social workers, psychiatrists, psychologists, mental health technicians, addiction specialists, and peer counselors. These teams operate under the auspices of voluntary agencies and municipal hospitals, responding to persons in the community, usually visiting them at home, although their mandate allows them to make contact at other locations.

Mobile crisis teams serve any person in New York City who is experiencing or is at risk of a psychological crisis and who requires mental health intervention and follow-up support to overcome resistance to treatment. Mobile crisis teams are often called by family members, neighbors, friends, landlords, clergy, or other person(s) concerned about an individual.

Mobile Crisis Team staff provide a range of services including assessment, crisis intervention, supportive counseling, information and referrals, linkage with appropriate community-based mental health services for ongoing treatment, and follow-up.

Often the assistance of a mobile crisis team is requested for a person identified as homeless. In such instances, the teams contact DHS to verify the homeless person's location within DHS. To ensure full collaboration, the DHS Medical Director's Office promptly alerts the shelter to a mobile crisis team's imminent arrival to evaluate the client.

In CY15, there were 246 mobile crisis team referrals for shelter residents.

### **Naloxone in Shelters**

Drug overdose is a serious public health concern and opioid-related overdoses have increased as a health threat. A life-saving law took effect on April 1, 2006, making it legal in New York State for non-medical persons to administer naloxone to another individual to prevent an opioid/heroin overdose from becoming fatal. Naloxone (Narcan) is a medicine that reverses an overdose by blocking heroin or other opioids in the nervous system for 30 to 90 minutes. In shelters, naloxone is administered intra-nasally.

The DHS Medical Director's Office began training shelter staff as certified Opioid Overdose Responders in 2009. To date, all DHS Peace Officers are trained in naloxone administration and are certified Opioid Overdose Responders. DHS Peace Officers administer naloxone in DHS directly-operated shelters and in contracted shelters where they are stationed. DHS has also been working with all contracted shelters so that they become Opioid Overdose Prevention Programs (OOPP), and many contracted shelters now have their own OOPP's and train their staff. Since 2009, 1,193 Peace Officers and 2,787 shelter staff have been trained to become certified responders.

Our immediate goal is to train shelter staff and some residents at all directly-operated and contracted shelters as Opioid Overdose Responders in 90 minute sessions offered over several days by the end of this calendar year thereby ensuring enough staff are trained to offer 24/7 coverage in every shelter. This will be done by training a select number of shelter staff as trainers who will in turn train other staff at their shelters. In addition, we are providing naloxone administration kits to every shelter to be kept in an easily accessible central location at the shelter to which trained staff shall have access.

To date, we conducted a survey to identify those shelters in need of naloxone training. All adult family and FWC shelters that require it will obtain training and certification by the end of 2016. Most single adult shelters already have fully trained and certified staff, as do all of the street outreach programs; the remainder will also be required to participate in training and will receive naloxone kits by the end of the calendar year. In addition, NYU medical students have been training clients at the 30<sup>th</sup> Street shelter.

By ensuring widespread availability of naloxone training, certification and kits among shelter staff, including having staff able to train others at their shelter, as well as some residents, we expect to significantly reduce the incidence of overdoses and OD deaths. In calendar year 2016 (to date), there were 79 naloxone administrations with 66 lives saved and 13 deaths after an attempted reversal.

### **Chronic Public Inebriates Pilot**

The chronic public inebriate pilot program is a joint initiative of Bellevue Hospital Center, DHS, and the Goddard Riverside Community Center. Bellevue identified the most frequent emergency department users who were thought to be street homeless and had been diagnosed with at least one alcohol-related disorder during an emergency department visit. With the patient's consent, the hospital and DHS Outreach Teams provide case management and help place the individual in a stabilization bed or safe haven. The ultimate goal is permanent housing placement, thus improving each client's health and decreasing the risk of death. Preliminary data from the pilot show a 38% and 35% reduction in hospital emergency department visits and in-patient days, respectively, as well as a reduction in associated costs for individuals enrolled in the program. The majority of program participants (79%; 19 of 24) are in transitional or permanent housing. DHS recently expanded this program to two additional NYC hospitals, St. Barnabas and Lincoln Hospitals in the Bronx.

### **Retraining and Security Action Plan**

The NYPD assigned a management team to be placed at DHS and developed an action plan to upgrade security at all shelters. The NYPD also retrained all DHS security staff. Currently all non-cluster shelters have some level of security provided by either DHS Peace Officers or by private

security guards. And as part of the 90-day review, security was increased at mental health shelters and commercial hotels.

This Administration has substantially increased spending for security at homeless shelters. Direct spending by DHS on DHS peace officers and contracted FJC security guards has increased 63% from \$48 million in FY13 to \$78 million in FY16. In addition, DHS reimburses shelter providers for their security costs, which was \$62 million in FY16, for total of \$140 million in security costs.

I would now like to respond to the bill before this committee, Intro. 932, which would require the Department of Homeless Services to submit to the Council and post on its website annually a report containing information on mental health services provided to individuals in shelter. We support the intent of this legislation and agree with this body on the importance of reporting to promote transparency and accountability. We welcome working with the Council on potential modifications in order to develop reporting metrics that will be clear and useful, and which will accurately capture the work of DHS as it relates to mental health care services in shelter.

Thank you for the opportunity to testify today and to respond to the bills before each committee. We welcome your questions.