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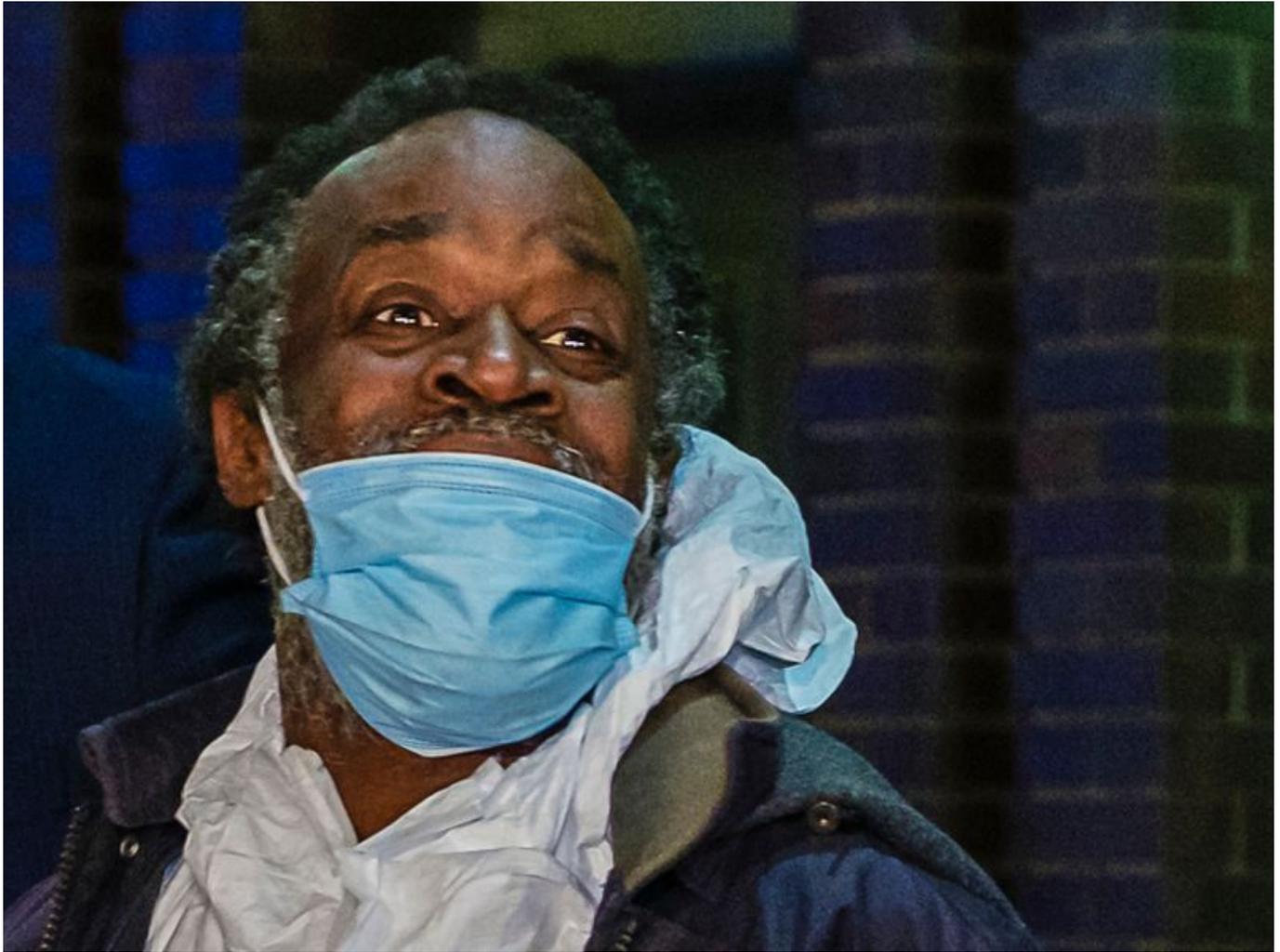
OPINION

When homeless New Yorkers are in psychological distress

By EILEEN TORRES and JOE DEGENOVA
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Simon Martial (Jeff Bachner/for New York Daily News)

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Our city collectively mourns the recent tragic deaths of [Christina Yuna Lee](#) and [Michelle Go](#). While the backgrounds of the individuals who allegedly killed them continue to be investigated, there are renewed calls to action to prevent devastating incidents involving people with histories of homelessness who are in suspected psychiatric distress.

As leaders of two nonprofits that have provided homeless services and street outreach for decades, we know tragic cases like these involve a rare subset of the overall homeless population — but they are nevertheless the result of a flawed system.

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To prevent similar situations, our city and state leaders should look at the systems that support people who experience both homelessness and Serious Mental Illness, and chart a path forward that includes more collaborative care. Specifically, [we need better communication and shared strategies between community-based homeless services and mental health providers, including in our city's hospitals.](#)

[Two-thirds of New Yorkers experiencing homelessness have mental health needs](#), and approximately [17% have a Severe Mental Illness \(SMI\) diagnosis](#). To be clear, the vast majority of individuals experiencing homelessness in New York City are living in shelters and functioning day-to-day. It is a harmful misconception and wholly incorrect to broadly label people experiencing both homelessness and mental illness as dangerous. Nonprofit homeless service providers and outreach teams build relationships with individuals experiencing homelessness and SMI and connect them with local mental health services. In many cases, outpatient care is an effective tool.

But for individuals in acute psychiatric distress who may be a risk to themselves or others, hospitals with inpatient psychiatric units are essential to help stabilize patients in crisis and provide the care they need. Coordinated aftercare with community resources like homeless service providers and outpatient mental health services is crucial to ensure a patient's long-term mental health management and improvement.

Unfortunately, [inpatient psychiatric beds in New York have declined](#) for years, even as the city's population has grown, due to poor Medicaid reimbursement incentive structures for inpatient facilities — and [more beds have been lost amid the pandemic](#). The effect is a dynamic that encourages hospitals to discharge patients prematurely, if they are admitted at all. As a result, it is difficult or impossible for hospitals to properly coordinate with community providers who can ensure continuity of care. In this system, homeless individuals with acute psychiatric needs are left to seek care from hospital emergency departments or return to the streets or shelter.



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Lack of coordination is not only leading to poor health outcomes but also to increased criminalization of mental illness, because we over-rely on police and incarceration instead of mental health care. Data from [Rikers Island shows that the average stay for individuals with mental health concerns is 215 days, compared to 42 days for the general population](#), compounding the trauma associated with incarceration. These individuals are more vulnerable to abuse from other inmates, and more costly for correctional systems, which must pay for psychiatric treatment, medication and additional staffing.

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Though the issue of providing care to individuals experiencing homelessness and serious mental illness is multifaceted, there are straightforward ways we can start to change the dynamic and reduce risk. The city can help by establishing standard policies and procedures for hospitals and community providers to communicate and collaborate regarding the care of people with SMI. Ensuring hospitals receive adequate resources to treat patients who need care is paramount, as is providing homeless service and community care providers with a streamlined way to report concerns to help prevent inappropriate hospital discharges.

It is crucial to improve funding and resources for outpatient and community care, like Assertive Community Treatment (ACT) and Intensive Mobile Treatment (IMT) models, which have a demonstrated impact. The city should also expand access to non-emergency crisis resources like NYC Support and Connection Centers, which are currently only accessible after a 911 call. At a minimum, community providers should be allowed to make referrals to these Centers.

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It is also necessary to look at our use of court-mandated mental health treatment, also known as Assisted Outpatient Treatment (AOT), for individuals who have been determined to be a risk to themselves or others. While decisions around AOT should never be made lightly, nor should they be “easy” to obtain, the current process is extremely complex to navigate for hospitals or community-based providers. Addressing the petition process could allow for providers to better advocate for patients in their care, improve discharge planning, and prevent future hospitalizations after an acute psychiatric episode. [AOT recipients show a 63% reduction in reported episodes of homelessness, a 66% reduction in hospitalizations, and a 73% reduction in incarceration.](#)

Relatively modest investments in improved coordination between community providers and hospitals regarding inpatient care, in addition to dedicated resources for outpatient care, will go a long way towards improving the wellbeing of the small group of people living with serious mental illness who pose a risk to themselves or others. It will also mitigate trauma and high costs associated with criminalization of SMI, and prevent future tragedies connected to acute psychiatric episodes.

Torres is executive director of BronxWorks. DeGenova is president and chief executive officer of the Center for Urban Community Services.

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