Testimony of Steve Coe, Chairperson,
New York State Campaign for Mental Health Housing

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Good afternoon. My name is Steve Coe and I'm executive director of Community Access, a mental health housing agency in New York City. Today I'm representing the views of a state-wide coalition I helped form in 2004, called the New York State Campaign for Mental Health Housing. The Campaign is composed of mental health providers, consumers, family members, housing developers, social policy experts, legal rights organizations and concerned citizens dedicated to ensuring that people of all ages living with mental illness in New York State have access to safe, affordable housing and the opportunity for an active life in the community.

Thank you for giving me the opportunity to testify today.

I'd like to make two points:

1. Recovery from mental illness is possible
2. Cost-effective strategies are available to significantly expand housing opportunities for people diagnosed with severe mental illness

Recovery from Mental Illness is Possible

Since the late 1970's, mental health treatment and practice, by fits and starts, has transformed itself from a system that promoted institutional, custodial care to community-based services that

emphasize, recovery, education, and employment. In the past, people diagnosed with mental illness could anticipate a lifetime of dependence on public institutions, abject poverty, and isolation from the community. Today, best practices rely on the on-going support of friends and family members, providing opportunities for a productive and meaningful life, and, most essentially, helping people secure a home.

In 2002, the report of the President's New Freedom Commission on Mental Health, chaired by the current OMH Commissioner Mike Hogan, stated the following:

"…after reviewing research and testimony, the Commission finds that recovery from mental illness is now a real possibility. The promise of the New Freedom Initiative—a life in the community for everyone—can be realized."

The report further states that:

"…The Commission believes it is essential to address the serious housing affordability problems of people with severe mental illnesses who have extremely low incomes. …Research shows that consumers are much more responsive to accepting treatment ***after*** they have housing in place. People with mental illnesses consistently report that they prefer an approach that focuses on ***providing housing for consumers or families first.***"

Cost-Effective Strategies are Available Now

The principles outlined above—recovery, employment, family support, and integrated housing—are all consistent with the programs, policies, and objectives of the New York State Office of Mental Health. The question becomes how to achieve these goals in a way that is both expeditious and cost-effective. Expeditious because we do not want to create another generation

of people for whom institutional, dependent care is the norm; and cost-effective because we need to leverage our limited resources to the best possible advantage.

Current Needs and Strategies

The New York State Campaign for Mental Health Housing estimates that there are over 10,000 people with psychiatric disabilities still in shelters, and 12,000 more in adult homes and nursing homes that were intended for the frail elderly. At least 9,000 people with psychiatric disabilities are released annually from New York's jails and prisons, 1,500 young people with mental health housing needs leave foster care each year, hundreds more are poised for discharge from inpatient settings with nowhere to go, and thousands of individuals with mental illness are living with aging parents or family members who are poorly equipped to handle the needs of their loved ones.

While the numbers seem staggering, there is a lot that can be done today.

First, New York State is endowed with a system of community-based mental health housing that is the envy of the nation, if not the world. Over 24,000 units of housing have been developed in our communities—from 6 bed group homes, to large apartment complexes. Making optimum use of this valuable resource is the first step to addressing the need. About half of these 24,000 units are transitional "beds," and could be re-tooled to accommodate the needs of people re-entering the community from prisons, jails, and other institutional settings. Today, the average length of stay in an OMH-supervised community residence is 17 months. In the transitional apartment program it's almost two years. The vast majority of these people could be moved to less structured and less expensive housing, almost immediately.

I'm delighted to report that the Office of Mental Health and the mental health housing community, in particular the leadership of the Association for Community Living, have been working closely together over the past several months on strategies that would both preserve and transform the existing OMH housing system into one that would serve those who need this resource the most, including people coming from jails and prisons, and people with multiple challenges, such as those with dementia, or brain injury.

The existing system can also be adapted to help reduce the use of emergency and inpatient psychiatric care. Many consumers in crisis are admitted to hospitals simply because there is nowhere else to go. Research has shown that people who can be treated without inpatient hospital care are more quickly returned to community life and are less likely to experience repeated psychiatric crises. A new federal Medicaid waiver (1915i) is available to finance alternatives to hospital care and New York State, with its extensive system of community residences, is in an excellent position to take advantage of this new initiative.

Second, through a variety of government programs, New York State subsidizes the development of over 4,000 units of affordable housing each year. Few of these units (probably less than 10%), go to people most in need, such as mentally ill individuals living in transitional housing, adult homes, or those living with aging family members. Minor regulatory adjustments to these programs to target more units for people with mental illness could create at least a thousand new units a year from existing resources.

When given the opportunity, nonprofit and for-profit developers in New York Sate have led the nation in creating integrated models that mix affordable housing for families, formerly-homeless

singles, young adults, and the elderly. These models can easily be replicated if financing and support services are blended across agency boundaries. Besides the benefit these models have for the people living in them, there is the added measure of support such projects garner from the local communities. Integrated projects are rightly perceived to be affordable housing, not "special needs" projects.

The supportive housing industry has built over 34,000 units since 1990 using low income housing tax credits, loans, and capital grants from an array of state and local sources. Approximately 60% of these units are for people with mental illness. This is a mature industry with the capacity to do much more.

Third, the most economical approach to creating new housing is simply providing modest rent subsidies and supportive services. As stated above, thousands of people remain in expensive, transitional, licensed housing that could be better used as an alternative for inpatient care or for consumers awaiting discharge from state facilities or other institutions. Scattered-site housing, coupled with mobile, flexible support services could easily be the dominate paradigm in future years. Today, it's the largest single component of the OMH residential system: over 12,000 units state-wide.

Finally, family members have been largest "provider" of safe, affordable housing for people with mental illness to date. It is time to include them in the planning process and support their sacrifices. If programs were available, many families, are prepared to set up trusts, donate their homes to nonprofit agencies, and make other contributions to insure their loved ones never have to become homeless or enter an institution. Rather than send families away, as has been done in

the past, because their needs didn't fit the programs, let's fix the programs to take advantage of an invaluable and dedicated resource.

Conclusion

At a conference last spring, the new OMH Commissioner Mike Hogan, after visiting a state psychiatric center in New York City for the first time, reported what many of us have known for years: OMH hospitals have become housing for homeless people. The same can be said for our prisons and jails, the foster care system, and other expensive, but inadequate living situations. When you factor in the costs of repeated trips to an emergency room and other crisis services, it's not hard to imagine a more affordable, or humane, approach to helping people with mental illness.

There are many ambitious ideas afoot that would substantially overhaul the way in which the State finances affordable housing, including at least four dedicated trust fund proposals. We heartily support any and all ideas that will ease the burden of finding a home for people in recovery in from mental illness. I want to stress, however, that expanding housing opportunities in community-based settings for mental health consumers need not wait for these expansive and complicated ideas to be sorted out. We need to begin today and we have the experience, tools, and resources to do just that.

Thank you for your time and attention.

New York State Campaign
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