



NEW YORK CITY COUNCIL MEMBER

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36<sup>TH</sup> COUNCIL DISTRICT, BROOKLYN

# MENTAL HEALTH IS PUBLIC HEALTH



## Addressing Gaps in Mental Health Service Delivery in Brooklyn

District 36 Provider Directory  
List of Medical and Mental Health Resources

**MAY 2019**

**Opening Message**

We all have a role to play in improving access to mental health services. Despite important advances in efforts to make mental health an integral part of our public health system – from the Affordable Care Act (ACA) moving to expand mental health coverage, to reducing current health disparities, to ThriveNYC’s offering important awareness raising and capacity building strides forward, to Vital Brooklyn’s pathbreaking investment of \$1.4 billion in Brooklyn’s health care system – as community leaders, advocates, and as conscientious friends and neighbors, we can do still more. More to recognize the social isolation, trauma, and pain that inevitably follow from gaps in the system, more to break down barriers to needed services, and more to improve the wellbeing of our shared communities. The need for more action on our part is vividly evidenced by the suicide rate in Black children, age 5-12, being twice as high as the rate for their white counterparts according to the National Institute for Mental Health.

Aided by outreach to clinicians and community leaders, here I lay out additional steps that I believe can contribute to strengthening our mental health ecosystem. Timely care, quality care, culturally competent care – these are just a handful of the important aims that we must continue to press our healthcare system to deliver. The experiences of the communities I represent, Bedford Stuyvesant and Northern Crown Heights, resonate well beyond the boundaries of my district. The insights community groups and clinicians shared with me add value to the larger, city-wide policy discussion and will help guide us to more thoughtful provision and delivery of services across the board.

On December 8th 2018, I hosted a Mental Health Advisory Board meeting in my District Office on the topic of depression. Various professionals from the mental health community came together to present the services they provide to the constituents of District 36 (e.g. Interfaith Hospital, the New York City Department of Health and Mental Hygiene, ThriveNYC), and other representatives, Friendship Benches, came to introduce novel approaches that have shown to be effective. In the audience were community partners and constituents, gathering in an effort to connect, find out more about services available, and share their experiences navigating the web of services.

As the event unfolded, a person in attendance shared her experience seeking help for a longstanding mental health condition and being received and treated in a way she described as undignifying, traumatic, and unnecessary. I aim for this paper to be one step along the path toward ensuring that people seeking assistance will have a wholly different, more positive experience when they reach out for help to improve their mental health – an experience where people are treated with respect and dignity throughout the continuum of care and beyond. With that aim in mind, I seek to foreground approaches that facilitate access to care, optimize oversight and accountability of the people who are at the frontline, bolster both early intervention and community involvement, and improve police involvement and response.

We must continue to tap into the wealth of expertise offered in our communities. Clinicians, public health professionals, on-the-ground advocates, and community residents can all constructively contribute to this dialogue that takes us from policy to action. Together, I believe we can successfully overcome obstacles to deliver services, improve mental health outcomes; ensure our family, friends, and neighbors receive the care they need.

Yours in partnership,



Robert Cornegy, Jr.  
New York City Council Member, District 36

**Goal #1: Facilitate Access to Care**

**Rationale:** Macro-level and micro-level barriers to access mental health treatment in our district can be addressed by raising awareness and weaving peer support into the fabric of the community.

**Recommendations:**

- ❖ Train front-line people in the community to recognize signs and symptoms of mental illness and connect individuals with primary care
- ❖ Connect members of the community with culturally competent care
- ❖ Create non-traditional points of access for mental health care
- ❖ Refine efforts of, welcome, and hold accountable authorities on NYC Care initiative

**Goal #2: Bolster Early Intervention and Community Involvement**

**Rationale:** Pioneer a District-wide culture shift around mental health to abolish stigma and promote mental wellness

**Recommendations:**

- ❖ Infuse the values of ThriveNYC in local agencies where our constituents seek services by organizing Thrive Talks
- ❖ Improve mental health literacy in our constituent by offering Mental Health First Aid trainings at our district office

**Goal #3: Improve Police Involvement and Response**

**Rationale:** Limit unnecessary police involvement; reduce the criminalization of mental illness

**Recommendations:**

- ❖ Ensure that first responders are informed of partnering providers of mental health services by favoring the use of 1-888-NYC-Well Crisis Mobile Teams over the 911 system
- ❖ Establish a permanent Health Engagement & Assessment team (HEAT) at the 81st, 77<sup>th</sup> and 79<sup>th</sup> precincts

**Introduction and Background**

*There is no health without mental health; mental health is too important to be left to the professionals alone, and mental health is everyone's business.*

— Vikram Patel

The World Health Organization (2019) defines mental health as “a state of well-being in which everyone realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. This definition highlights that mental health is not merely the absence of illness, but rather the ability to lead a meaningful life regardless of a medical diagnosis. Since the movement aiming to integrate former asylum residents into the community in the 1950’s, the face of mental health services has changed greatly. As deinstitutionalization efforts continued into the 1990’s and 2000’s—increasingly driven by managed healthcare systems—poor planning and flawed execution often marred the process of providing a safe, healthy and successful patient transition back into society (Eide, 2018).

As a result, the needs of people with severe and chronic mental illness have become more complex and the services in place have shown to be insufficient and not properly coordinated. Typically, emergency rooms are crowded with acutely ill patients with long psychiatric histories but no plausible disposition for discharge (Yohanna, 2013), creating the well-known “revolving door” phenomenon. While research shows that the rates of mood disorders are consistently lower for Black Americans than they are for their white counterparts (Jackson, Knight & Rafferty, 2010), research also shows that the quality and consistency of care received by Black people, especially Black men, is poorer (American Psychiatric Association, 2017). Meanwhile, the

suicide rate in Black children age 5-12 is twice as high as the rate for their white counterpart (National Institute for Mental Health, 2018), and this warrants further attention.

Kings County, NY, totals 2.65 Million people, 36% of which is Black (US Census Bureau 2017). In Bedford Stuyvesant, Black people account for 64% of the population, in comparison to 22% for NYC overall (Community Health Profiles, 2018). The Black community in Bedford Stuyvesant is quite diverse with the most prominent groups being respectively from the Dominican Republic, Mexico, Barbados, Guyana, Jamaica and Trinidad and Tobago; Black people account for the largest racial group, making 53% of the population, followed by white (23.1%) and Hispanics (18.8%) (US Census Bureau, 2016) ([www.osc.state.ny.us/osdc/rpt5-2018.pdf](http://www.osc.state.ny.us/osdc/rpt5-2018.pdf)). For the sake of keeping it succinct, while making sure we accurately depict the disparities affecting the majority of our constituents, we will use “Black people” when referring to our constituency in this paper.

In a survey done by the Commission on the Public Health System (2012), Mental Health was reported as one of the services that was the most difficult to access in North and Central Brooklyn. In Bedford Stuyvesant, the rate of avoidable hospitalization is twice the city average and the rate of adult psychiatric hospitalization is higher than the citywide average (Community Health Profiles, 2018). There are a myriad of factors that make up the mosaic of District 36 that can partly explain why people in Bedford Stuyvesant forego treatment for mental health problems or use services ill-equipped to meet their needs; conversely, there are social, economic, and environmental factors pertaining to District 36 that shape the mental health of our constituents.

Historically, Americans have experienced variable access to care based on race, ethnicity, socio-economic status, age, sex, disability status, sexual orientation, gender identity and residential location (National Healthcare Quality and Disparities report, 2015), and Bedford Stuyvesant is no exception. The level of economic stress, namely high unemployment rate and lower income, its social and economic conditions (lower than city average level of trust in neighbors, higher levels of policing in Black and Latinx community), and housing and neighborhood conditions (housing, pollution, food environment) (Community Health Profiles, 2018), are all characteristics that can lead to mental health problems, and also affect pathways to care and service usage.

In the following pages, I will explore the topic of mental health as it relates to the population of District 36 and present solutions that could be implemented, or at least piloted locally, to improve how my constituents interact with mental health services.

### **Goal #1: Facilitate Access to Care**

*You certainly can't prevent all mental health problems - factors like genetics and traumatic life events certainly play a role. But everyone can take steps to improve their mental health and prevent further mental illness.*

— Amy Morin

Measures of access to care include having health insurance, having a usual source of care, encountering difficulties when seeking care and receiving care as soon as wanted (National Healthcare Quality and Disparities report, 2015). Given the demographics of District 36

described earlier, I will add another consideration relating to the stigma associated with seeking help for one's mental health.

### Encountering Difficulties When Seeking Care

In the Fall of 2018, councilmanic staff from my district office conducted comparative review visits and immersed themselves in the experience of seeking care at two of the main providers of psychiatric services in the District: Woodhull Hospital and Interfaith Medical Center. The goal of the review was to account for some of the personal obstacles encountered when seeking help for behavioral health treatment in large hospitals and evaluate the need for non-traditional spaces to find help for mental health. In both instances, councilmanic staff reported that they had to ask for directions and guidance about where to check-in for admission and felt overwhelmed with the process.

Staff reported the experience felt impersonal and there appeared to be a disconnect between the stressful reality of the needs of someone experiencing a mental health crisis and the bureaucratic hoops one has to jump to get through to services. Meanwhile, my district office receives calls on a regular basis from constituents and providers alike who are at a loss for where to find community-based mental health services in District 36. A lot of people think that care is solely found in hospitals; if their experience resembles that of my staff, they might abandon the mission to find help altogether. I want my constituents to know that hospital emergency rooms are only one source of care, and more often than not, probably not the level of care they need.

### Having a Usual Source of Care

Upon visiting local hospitals, there was a greater understanding of the choice of the verb “navigate” to describe the health system. To get around the complex maze of services, one needs tools, navigation skills, and some patience, which might be difficult to marshal in the midst of a mental health crisis. In an ideal world, care would be coordinated seamlessly and service users would not have to put time and effort into anything else than going to appointments and adhering to their treatment. One valued model with positive outcomes is the Collaborative Care Model. This model of integrated care has shown both efficacy and efficiency (American Psychiatric Association, 2018). In this model, primary care is combined with behavioral health into a coordinated, evidence-based approach to patient-centered care that reduces the barriers to receiving care and is linked with high patient satisfaction (APA, 2018).

Bedford Stuyvesant Family Health Center offers behavioral health services according to this model at its main office on 1456 Fulton Street. Informing my constituents about the advantages of forming a relationship with a provider in a primary care setting-as opposed to trying to figure out where to go in the midst of a crisis-is a goal we should attempt to achieve to avoid unnecessary use of the highest level of care, namely the Emergency Department or inpatient services.

### Reviewing Wait Times in Emergency Rooms and Receiving Timely Care

Delays before getting care in the emergency department can reduce the quality of care and increase risks and discomfort for patients with serious illnesses or injuries (Hospital Compare 2018). According to the most recent report from the New York State Department of



Health, the average time patients waited in the emergency room before being seen for a diagnostic evaluation by a health care professional was 46 minutes at Interfaith and 99 minutes at Woodhull, compared to the statewide average of 21 minutes.

Another consideration with regards to access to care is the timeliness of treatment. Poor childhood mental health is a gateway to adult mental health problems, which have a significant social-emotional, economic and educational burden. By acting early and preventatively, the course of mental illness can be altered and perhaps even avoided. While ThriveNYC has made a commitment to teach Social Emotional Learning at all Early Learning and Pre-K levels, children's mental health should be further integrated into primary care. There is no good reason to separate physical from behavioral health, since we know mental health impacts physical health and physical health impacts mental health (National Alliance on Mental Illness, 2011). There are a myriad of advantages in coordinating care under one provider for everyone, especially for families of young children. Early education, detection, intervention, avoiding delays related to the transfer of care (which sometimes discourages efforts to get help), and facilitating communication serve as a more efficient way to ensure that care is received in a timely manner.

### Health Insurance

As recently as 2012, forty-seven million people were completely uninsured, and many others with insurance faced high out-of-pocket costs that hindered care and bankrupted more than a million annually (Himmelstein & Woolhandler, 2008). Approximately 28.5 million people did not have insurance at a point in 2017 (US Census Bureau, 2018). In Bedford Stuyvesant, 11% of adults do not have health insurance, similar to the citywide average of 12%; in Bedford Stuyvesant, 23% of resident live in poverty, which is slightly higher than the NYC average of

20% (Community Health profiles, 2018). Insurance coverage is an elementary part of access and continuity of care. In a social context where healthcare relies heavily on market mechanisms and for-profit firms, we need to double up on efforts to craft local solutions to ensure that our community's needs are met.

In January 2019, Mayor De Blasio announced that his administration will launch the largest, most comprehensive plan in the nation to guarantee health care for every New Yorker. The plan will serve the 600,000 New Yorkers without insurance by strengthening NYC's public option, MetroPlus, and guaranteeing anyone unable to afford or ineligible for insurance – including undocumented New Yorkers – has direct access to NYC Health + Hospitals' physicians, pharmacies and mental health and substance use services through a new program called NYC Care. All services will be affordable on a sliding scale. The programs will include customer-friendly call lines to help New Yorkers – regardless of their insurance – make appointments with general practitioners, cardiologists, pediatricians, gynecologists and a full spectrum of health care services (“Mayor de Blasio Announces Plan to Guarantee Health Care for all New Yorkers”, 2019). This initiative is timely and will likely impact the insurance coverage of people in District 36. We must work to make this promising program a success, follow closely when it rolls out, and ensure our communities are aware and taking full advantage or enrolling.

### Cultural, Personal and Institutional Barriers

Stigma is defined as a complex social process of labeling, othering, devaluation and discrimination involving an interconnection of cognitive, emotional and behavioral components

(Link & Phelan, 2001; Corrigan, Druss & Perlick, 2014;15). While there is no formal data to document this issue specifically in my district other than personal accounts of constituents, it is a pervasive, well-documented problem across the spectrum of healthcare (Knaak, Mantler & Szeto, 2017; Pellegrini, 2014). Lay persons and even medical professionals are concerned about “labeling.” Negative attitudes and behaviors, lack of awareness, therapeutic pessimism, lack of skills and the stigma in the workplace culture have been identified as the “key learning needs” and have shown to delay help-seeking, discontinue treatment, suboptimal therapeutic relationships, patients safety concerns, and poorer quality mental and physical care (Knaak, Mantler & Szeto, 2017).

Another important challenge to consider is that less than 2% of the American Psychological Association members are Black/African American (Mental Health America, 2019). The concern that professionals are not culturally competent to treat their specific issues, compounded by the fact that some Black/African American patients have reported experiencing racism and microaggression from therapists, is a legitimate barrier to accessing treatment (Mental Health America, 2019). Throughout U.S. history, the Black community has faced inequities in accessing education, employment, and health care. However, strong social, religious, and family connections have helped many African Americans overcome adversity and maintain optimal mental health.

Many Americans, including African Americans, underestimate the impact of mental disorders. Many believe symptoms of mental illnesses, such as depression, are situational “blues.” Some research indicates that Black people believe they would be labeled as “crazy” if they were to disclose issues with depression and anxiety to their communities and even to their

own families (Mental health America, 2019). Social scientists report that the level of religious commitment among African Americans is high. In one study, approximately 85% of African Americans respondents described themselves as “fairly religious” or “religious” and prayer was among the most common way of coping with stress. Because African Americans often turn to community—family, friends, neighbors, community groups and religious leaders—for help, the opportunity exists for community health services to collaborate with local churches and community groups to provide mental health care and education to families and individuals.

While rates of mental illness in African American individuals are similar to the general population, there are disparities with regards to service quality and accessibility to culturally competent care. Contributing factors include the lack of trust in health care providers among people of African descent (Armstrong, 2007) and the increased likelihood African Americans use the ER compared to their white counterparts, who seek help in settings that offer longer-term, better quality intervention (Tweedy, 2015; Arnett & al, 2016; Weinick, Zuvekas & Cohen, 2000). Some research even shows that Black people are more likely to receive drugs instead of psychotherapy when evidence shows that the former is the more effective form of treatment (Panel on Race, 2004).

In the United States, boys and men are less likely to report depression than women and girls, and they have higher rates of suicide completion and drug-related deaths. Research on the intersection of stigma and race/ethnicity is showing that the negative perception of mental illness is greater among Black and other minorities than among White people. One hypothesis to explain this difference is the fear Black people experience, based on historical experience that disclosing a problem with their mental health is going to lead to confinement (Alvidrez,

Snowden, and Kaiser, 2008, p. 875). Medical mistrust is indeed so strong in the Black community that it is linked with low value healthcare utilization and accounts for the disparity for Emergency Care over Primary Care as a site of usual source of care (Arnett & al, 2016).

### Breaking Down Barriers to Care

Engagement with a primary care provider when well paves the path to care when experiencing a mental health crisis and increases the likelihood of actually receiving the type of care needed. Compiling a list of culturally attuned providers in the district serve to increase the likelihood of finding a provider that understands community needs. My office has compiled a list of culturally attuned mental health providers in our district. Another way to overcome the barriers of accessibility to care and racism is to weave support into the fabric of our community, through peer-lead support and involvement of key community members.

Peer-support specialists give hope and encouragement that mental health challenges are not necessarily permanent and that one can lead a meaningful and productive life. They can help one learn how to be effective in communicating needs to care providers and social circles from a place of lived experience; are able to provide tools to prevent a mental health crisis from escalating; help people break out of isolation; provide information about supportive services like supportive housing or supportive employment to help someone get back on their feet. Peer-led support is undoubtedly helpful, and we would like to see key members in our community get trained in ThriveNYC Mental Health First Aid so they can catch signs and symptoms before it is too late.

For example, beauty parlors and barbershops are places of connections, loyalty and trust. Historically, these salons have hosted voter registration campaigns, political discussions, and sports events viewings, making the venue a pillar of the Black community (Wilson, Kaboolian, de Jong, Stuart, 2017). According to Joseph Ravenell, medical doctor and men's health advocate, "Black men trust their barbers more than they trust their doctor-most men have been with their current barber for about 8 years and they see their barber every two weeks" (TED, 2016). It is no surprise that lately, trained barbers team up with the healthcare system to address health disparities faced by Black men, and this is something we can play a role in catalyzing in District 36 and beyond.

The Friendship Benches Initiative is another initiative we should nurture on the streets of Bedford Stuyvesant/Northern Crown-Heights. It is a peer-led initiative that meets in non-traditional settings to bridge the gaps in mental health care. It uses a problem-solving approach as well motivational interviewing to help community members identify their strengths and resources; it also helps link people to the professional services they need. Friendship benches is already in full-swing in Harlem and the Bronx, and it has shown to enhance community engagement, increase access to care, reduce symptoms of depression and anxiety and increase social cohesion (Fund for Public Health NYC). Globally, the Friendship Bench Initiative has not only been used to treat common mental health disorders, but is also used as an approach in the development and evaluation of mental health intervention for people living with HIV (Chibanda, Verhey, Munetsi, Cowan, & Lund, 2016; Verhey, Chibanda, Gibson, Brakarsh, & Seedat, 2018).

More street-level promotion of the ThriveNYC initiatives and mental health services available in my district would also help break down barriers to care. For example, the LinkNYC

kiosks hold a wealth of information about local mental health providers; but it had to be brought to my attention and once I knew about it, I had to rummage through the general content to access mental health information and guides. I would be curious to see the effect of advertising that free resource could have on my constituents accessing help in the district. My team suggested using the advertising space on the kiosk itself to promote mental health resources; I see even bigger: I want 1-888-NYC WELL (1-(888)692-9355) to be on everyone's mind, the same way most of us can come up with the phone number jingle for various products. Lastly, the local NYC Human Resources Administration (HRA) portal and mobile app should feature mental health resources and serve as another point of access for connecting New Yorkers with access to care.

### **Goal #2: Bolster Early Intervention and Community Involvement**

*"I think, actually, it should be in our schools," he continued. "Children have the most going on...social anxiety and all these things are happening to you, and you don't have the language to navigate it."*

—Jay-Z

ThriveNYC highlights in its mission statement the relevance of early intervention, the need for suicide prevention and the importance of community involvement at a City level. I cannot agree more, and hope to create solutions tailored to our community to ensure that needs are addressed promptly and adequately.

### Suicide prevention and early intervention

At least one in five adult New Yorkers is likely to experience a mental health disorder in any given year and 8% of NYC public high school students report attempting suicide (ThriveNYC). While the national trend suggests that suicide rates are higher in white than Black

people across all age groups, suicide rates increased from 1993 to 1997 and 2008 to 2012 among black children aged 5 to 11 years (from 1.36 to 2.54 per million) and decreased among white children of the same age (from 1.14 to 0.77 per million) (Bridge, Horowitz, Fontanella & al., 2018). An estimated three quarters of mental health disorders begin before age 24, and half begin before age 14; early intervention is important, providing parents with preventative interventions reduces the risk of their child developing a mental health condition later in life by 40% (ThriveNYC).

### Community involvement

Communities play a crucial role in addressing mental illness and addiction. Community members and faith leaders can improve mental health by educating their communities, identify opportunities to support those who suffer from mental illness, connect individuals and families with the help they need and promote acceptance of those with mental health issues (MentalHealth.gov, 2019). Sadly, a recent study revealed that residents of Bedford Stuyvesant believe that their neighbors are willing to help one another at a lower level than city average (Community Health Profiles, 2018). I believe that promoting and coordinating mental health training for community members might contribute to increase the level of trust our constituents have in one another and facilitate access to care, and this is why we commit to promote Mental Health First Aid Training for our constituents at our district office, alongside the other ideas mentioned above to mobilize key community members to become able to detect signs of mental illness early.



In addition, a sustained public awareness campaign would aid in raising visibility around the issue of mental health. Advertising resources more broadly on an ongoing basis would further help connect community residents to resources; I envisage a broad public service announcement campaign to include train stations, buses, LinkNYC kiosks, among other media. This step is particularly warranted due to the ongoing challenge of people not knowing who to call and where to go,

### **Goal #3: Improve Police Involvement and Response**

*There isn't anybody out there who doesn't have a mental health issue, whether it's depression, anxiety, or how to cope with relationships. Having OCD is not an embarrassment anymore - for me. Just know that there is help and your life could be better if you go out and seek the help.*

— Howie Mandel

It is common for people to think that people with a mental illness are dangerous, or conversely, that people committing crimes have a mental illness. This societal bias contributes to the stigma faced by those with a psychiatric diagnosis. In turn, stigma contributes to non-disclosure of the mental illness and decreased treatment seeking; stigma also leads to discrimination (Varshney, Mahapatra, Krishnan et al., 2016). Research shows that 95-97% of gun violence is not caused by a mental illness and that overall, those psychiatric patients who are violent have rates of repeated aggression somewhere between the general population and a criminal cohort (Bonta, 1998).

A tragic consequence of the deinstitutionalization movement has been the difficulty people with severe and persistent mental illness face finding adequate housing. Formerly living

in psychiatric facilities, individuals with severe mental illness face important challenges finding and maintaining housing and some unfortunately end up on the streets, in shelters, or in jail. Today, the largest U.S. jails and prisons hold more people with mental illness and co-occurring substance use disorders than most inpatient psychiatric facilities; prisoners suffering from mental illness are more likely to have experienced homelessness, prior incarceration, and substance abuse than those without mental illness (The Center for Prisoner Health and Human Rights, 2016). These factors, common among offenders, also predispose them to mental illness (Becker Cohen & Kim, 2015).

In an effort to address the decriminalization of mental health illness, NYC Health and the New York Police Department (NYPD) recently implemented “Co-Response Teams” (CRT) consisting of at least 2 staff members from the Department of Health and Mental Hygiene (comprised of social workers and peer support specialists) accompanying NYPD officers to address the gap between the medical system and the judicial system. Since its inception in March 2016 and up until January 2019, District 36 accounted for 27% of all co-responsive team interventions that came from Brooklyn (NYC Health). Between November 5, 2018 and December 31, 2018, 16 Co-Response Teams were deployed to District 36 and close to half of the individuals that were engaged (n=27) were Black or African Americans, with a 20:7 male to female ratio (NYC Health).

Co-Response Teams are not based in local precincts, but rather are centrally located within the NYPD and deployed when deemed appropriate based on the nature of the 911 call. The team’s availability is inversely proportional to the number of calls placed with 911, offering no guarantee that someone in a mental health crisis will benefit from this specialized first

response. Since District 36 has been a high service user for CRTs, having a permanent co-response team at our local precincts duly matches resources to community needs.

Diversion Centers are short-term, stabilizing services for individuals with mental health and substance use needs that offer police officers a much-needed alternative to arrest or hospitalization (NYC.gov, 2018). We should follow closely as the first two diversion centers open in the Bronx and East Harlem and pursue opening a diversion center in Bedford Stuyvesant.

The school to prison pipeline is a disturbing national trend, where children are funneled out of public schools and into the juvenile and criminal justice system (American Civil Liberties Union, 2019). What is even more disturbing is that this trend disproportionately impacts children of color and children with disabilities. According to the ACLU (2019), “students who come in contact with law enforcement and the criminal justice system because of their in-school behaviors have a greater likelihood of continued interaction with the criminal justice system”. According to a study funded by the National Institute of Mental Health—the largest ever undertaken—an alarming 65% of boys and 75% of girls in juvenile detention have at least one mental illness.

Youth living with mental illness are being incarcerated, some as young as eight years old, rather than identifying their conditions early and intervening with appropriate treatment. With that in mind, and given the demographics of District 36, we believe that mental crisis occurring within schools should be addressed de facto by mobile crisis teams (NYC Health) or CRTs. The benefit of a specialized first response are even greater for children and youth. Further, it models how to address a mental health crisis and sends a message that asking for help when in distress is not a criminal offense.

Access to mental health services is deeply rooted in the housing crisis, where those with severe mental illness are more likely to be or become homeless without treatment (Zhang & Brakenhoof, 2017). There is strong evidence characterizing housing's relationship to health. Housing stability, quality, safety, and affordability all affect health outcomes, as do physical and social characteristics of neighborhoods.

### **Concluding Thoughts**

*Why care? Because care is a simple word, but a powerful way to change lives for people affected by mental illness. We care because we are in this together.*

*— National Alliance on Mental Illness*

Many important factors intersect with mental health service provision that I am unable to explore fully here: housing, substance use, and the fundamental differences in the needs and realities of people with severe and persistent mental health problems such as schizophrenia and bipolar disorder, and those people with less severe, transient mental health needs. Yet this exploration and documentation of a set of limited solutions helps serves as an entry point into those larger discussion as to how we can address the needs of New Yorkers across the spectrum of mental health. We must aim to make mental health part of the everyday conversation about health in general and continue a sustained focus on overcoming challenges as we uplift the well-being of all our shared communities.

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