

Mental Hygiene Joint Legislative Budget Hearing

2019-2020 Executive Budget Proposal

February 7, 2019

**Testimony by Virginia E. Davey, Statewide PEF/OMH Labor
Management Committee Co-Chair**

Good afternoon esteemed Committee members and friends of those attempting to assure that mental health care needs are adequately met in our communities. My name is Virginia E. Davey and I am speaking on behalf of the Public Employees Federation. I have been working for the Office of Mental Health since 1991. As PEF reviewed the OMH Budget for the 2019 Fiscal Year, there was much to celebrate for people with mental health challenges as well as some opportunities to offer insight and clarification from the front lines on the fight to maintain quality care for our most vulnerable citizens. The ongoing commitment to serve more individuals, under a streamlined budget, is a challenging feat for those trying to stretch the almighty dollar to its maximum benefit for those who are in need of mental health support and treatment. As the OMH-PEF Labor Management Co-Chair for the last four years, I have been in a unique position to hear from both labor and management regarding the challenges that we face and the obstacles we encounter when trying to execute OMH's Transformation Plan. Of late, the most pressing and debilitating issue has been staffing shortages related to an inability to recruit and retain the next generation of professional health care workers.

The "nursing crisis", as we have come to call it, has both labor and management trying to up their game to convince qualified individuals to work for New York State. Despite employing many old school and new school recruitment strategies, OMH has experienced limited success recruiting in a low supply, high demand, healthcare world. The SFY 2019 Budget remains silent on the biggest threat to the quality of care for New York State citizens who live with mental illnesses. The need for the recruitment and retention of highly qualified professional staff has to be brought to the forefront of the fight to protect the most crucial psychiatric services available to the citizens of NY. This is a very serious matter and the need to act now to preserve quality of care cannot be overstated. In the past, many have heard me speak about the need to maintain the Professional, Scientific and Technical NYS workforce who serve as the backbone of the mental health delivery system in every NYS community. For years, PEF professionals have laid the groundwork for assuring that quality standards of treatment are established and maintained in OMH facilities. Licensed mental health care

workers are under obligation to speak up when the envelope is being pushed to the outer limits. For months, the PEF choir has sung a sad song of diminishing quality of care. With inadequate staffing ratios, PEF members have found it increasingly challenging to keep up with the unrealistic productivity standards being promulgated by those seeking to streamline services. PEF understands that financial limitations, with regard to pay discrepancies between private sector and public sector employees, have siphoned the best and brightest professional talent away from caring for the most needy and vulnerable among us. PEF has been working in concert with OMH to try to mitigate the barriers to hiring qualified staff, but the obstacles to success have been many. PEF is asking that you, our elected leaders, find a mechanism for allocating funding for the sole purpose of assisting in the recruitment and retention of qualified professional staff in OMH. These efforts would serve to shore up the underpinnings of an essential, invaluable, and quality driven mental health service to NYS citizens. Along with enhanced funding, a review of any Civil Service Law that prohibits OMH from making use of hiring incentives, that are already available to private sector employers, is essential. Expanding the loan forgiveness programs further, to include professionals that are considered to be hard to recruit, would also go a long way toward leveling the playing field for NYS Public Sector employers. OMH and PEF are partners in trying to solve the recruitment and retention challenges and have joined forces to work within the available confines and strictures, which have in many cases tied our hands and diminished the possible returns achieved. Legislative assistance that would allow for a review and eventual readjustment of the salary schedules of public sector employees, so they are better aligned with private sector workers, would help to encourage adequate staffing levels in OMH facilities.

The ability to retain professionals has been very difficult. Newly hired employees have been asked to work in situations whereby staffing limitations have caused the workloads to be untenable. They have been asked to manage wards that have been chaotic and disruptive, due to fewer staffs being available to manage ongoing treatment needs and the resulting disruptions. Nurses have been regularly mandated for over-time. Days off have been nearly

impossible to attain due to staffing shortages, etc. Nurses have often left state service due to the unwavering intensity of job duties, coupled with the personal sacrifices related to mandatory overtime assignments and lack of opportunities for days off to recuperate and/or spend time with their families. In order for OMH to get back in the game, with regard to recruiting and retaining nurses, they will need to fill all vacant positions through incentives that serve to draw in a number of much needed nurses. Nurses will continue to leave state service, until the chaos of understaffing is no longer causing the job to be viewed as detrimental to the happiness, health, safety, and welfare of nurses.

PEF continues to assert that in order to maintain a structure of quality mental health care, the budget must take into consideration the numbers of individuals being newly identified as persons in need of mental health services. Many PEF members have lamented that they have been unable to keep up with the professional demands of their ever-increasing caseloads. They have spoken of scores of instances whereby they have been unable to maintain a standard of care that an objective observer would consider acceptable. PEF believes that additional financial resources must be allocated to hiring more professional and licensed staff for the outpatient Mental Health Clinics. Having those in need of mental health care waiting in line for service is a risky proposition that could prove disastrous. The lack of investment in the maintenance of proper staffing levels is undercutting our substantial obligation to provide quality mental health treatment to the citizens of NYS. PEF has called for less reliance on the private sector mental health providers when OMH has the building infrastructure to expand services and to allow for greater use of outpatient service capacity. In some communities, the current mental health needs have exceeded the available capacity to provide those services in a safe and timely manner. In such instances, there has been a groundswell of frustration and anger brought forward to OMH, PEF, and our political leaders due to the acknowledgement that mental health services are not adequate in their communities. With more community outreach at play, the need for services is constantly expanding, despite the flat-line budgetary commitments in the OMH budget.

Receiving health care in a mental health care system that is not adequately staffed disrupts the healing environment needed to foster recovery. With fewer people to tend to the recovery needs of individuals in treatment, the treatment milieu becomes chaotic and far less than therapeutic. The continued effort to do more with less, or to streamline operation costs in service delivery, has at times proven to be detrimental to our treatment goals. Decreasing minimum staffing levels and/or failing to fill vacated positions, has undercut the effort to maintain a safe and therapeutic environment. The establishment of minimum staffing levels could help to keep secure the integrity of mental health treatment for those requiring care in psychiatric hospital settings.

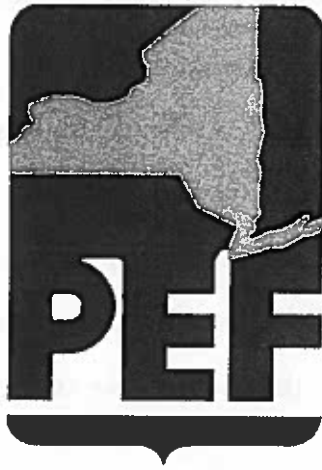
It is unfortunate that OMH is slated to vacate 100 more inpatient beds in favor of 200 more community-based supportive housing beds. Many social workers that are supportive of the provisions of the Olmstead Act have decried the need to better assess and prepare patients for their reintegration into community-based settings. Often, the move toward community-based care has been viewed as premature and ill- advised by counselors working with such individuals. PEF supports that a moratorium be placed on the further diminishment of inpatient services during FY 2019-2020 in order to allow for a more thorough and measured assessment of needs and a realigning of staffing in support of quality mental health treatment.

The use of “No Mandatory Overtime” has been significant due to the recruitment and retention challenges within OMH. This has created the very scenario that the No-Mandatory Overtime Law attempted to address. Aside from being very disruptive to the lives of PEF members, it is clear that consistency of care is best achieved with consistent staffing levels that assure that the workforce is competent, well trained, ready for duty, and rested. Often NYS employees are scrutinized due to the high salaries (OT) they are paid, even though much of the overtime costs result from inadequate staffing levels and the subsequent need for multiple involuntary overtimes. Analyzing the correlation between overtime use for hard to recruit titles would likely reveal a financial benefit to increasing hiring rates and/or

instituting Civil Service grade reallocations that would allow for competitive salaries for NY State employees.

Lastly, with regard to the proposed Jail-based Restoration Programs, PEF asserts that the care of persons requiring mental health services is best achieved in a hospital setting versus jail based treatment pods. Sadly, jails and prisons are already housing far too many individuals who would be better served in a health-focused environment that aims to heal and mitigate the negative consequences stemming from untreated mental illnesses. The Olmstead Act does seem to inform that the least restrictive environment, in a hospital setting, would be far more preferable, and more therapeutic, than any jail-based treatment alternatives. The money allocated for this additional funding would be better spent on recruitment and retention of mental health care professionals in OMH's 24 Psychiatric Centers.

On behalf of PEF President Wayne Spence, I thank you for allowing PEF to offer our testimony regarding the 2019-2020 SFY Budget. If we can be of any further assistance, please do not hesitate to reach out to us.



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Testimony by Christine Pettit, PEF Nurse Practitioner

Good afternoon esteemed leaders. Thank you to the distinguished committee members for taking time to hold these hearings to listen to stakeholders' needs and concerns. My name is Christine Pettit. I am a Nurse Practitioner in Psychiatry and have worked in various roles within OMH for the past 10 years. I have been asked by PEF leadership to speak on behalf of the PEF members, our communities and the vulnerable individuals we serve who are often voiceless within a dwindling public health care system. My professional colleagues and I continue to have concerns about another flat OMH budget especially in light of the opioid and mental health crisis and the profound deleterious effects these cuts have within our communities.

As we know, OMH has shared their vision of a "transformation plan of community based services" which quite frankly is outsourcing needed and vital programs that are delivered by qualified NY State professional employees. The proposed 2020 budget recommends significant investments in the OPWDD, OMH and OASIS not-for-profit workforce.

PEF hopes that we can help impact the financial decisions to allow for a more measured and thoughtful consideration of the needs of NYS citizens who require quality mental health care.

Transformation plan

The three pillars of healthcare are cost, quality, and access to care. OMH's transformation plan initially may have had good intentions. We, as licensed clinicians, are seeing the devastating effects within our communities and on the vulnerable individuals we serve.

The proposed budget recommends significant investments in the OPWDD, OMH and OASIS not-for-profit workforce. Where is the oversight of this money and who is providing the services? The very workforce receiving the "investments" in OMH funding continue to

discharge the most severely and persistently mentally ill, the complex cases are often closed due to missed appointments, complexity and acuity. These are individuals who are high utilizers of CMS services.

On page 50, of the report, *The OMH Transformation Plan, Advancing a Progressive Behavioral Health System*, lists ten major service areas supported through the Transformation Plan investment including “expansion of State and voluntary operated clinic programs” and “ten new or expanded Assertive Community Treatment (ACT) teams” (OMH, 2016-2020). The commissioner’s comprehensive plan 2016-2020 clearly notes that one of the top ten priorities in the expansion of state run clinics and ACT programs; however, so far since 2016 we have witnessed the closure of these vital state run programs. For example, the New Rochelle State clinic has closed as well as the state operated Monticello clinic in Sullivan County. There was also a recent attempt to close the New York State ACT team in Orange County and State Operated Community Residence (Middletown SOCR); however, those programs were saved due to the advocacy of PEF members and some members of this legislature.

Another example is on track NY. OMH tends to cite the number of individuals they have treated or admitted; however, they do not report how many individuals have been excluded from their services ultimately failing the promised delivery of assessable and cost effective quality mental health care to young individuals.

Access to Care:

Currently, are there waiting lists for the local community’s hospital psychiatric unit to transfer an individual to a longer-term hospital (state bed)? What are the consequences to the community and the local hospital? Community hospitals are not admitting individuals who are persistently mentally ill. They are unable to admit and transfer for longer-term

inpatient medically necessary treatment. These community hospitals and ER's have no other way to deal with the inpatient bed closures than by declaring sick people well and discharging them.

Inpatient psychiatric beds:

With the continued decrease of inpatient state psychiatric beds, the burden then falls within our emergency rooms and local acute psychiatric hospital beds that are not equipped to manage a longer term required admission. Jails continue to be flooded with severe and mentally ill individuals, homelessness increases, substance abuse and opioid abuse continues. The revolving door continues.

Community Residences/Transitional Residences:

OMH continues to close state operated community residences and downsize transitional residences. The counties across NY State have waiting lists for these vital intensive outpatient housing programs.

Supported housing:

We are placing an individual who requires an ICU level of care in an apartment with "wrap around services" by a non-licensed work force that cannot manage the individual within the community. The budget calls for continued "investments" in the not-for-profit workforce. The work force of non-licensed "case managers" has high turn over, provides little continuity and is ill equipped to manage a severe, mentally ill population.

Family Care Housing:

The commissioner continues to cite these programs will be increased and often they have decreased the beds for this type of housing.

Contracted Employees:

The proposed 2020 budget includes 443 contracted employees (48.9 million). Also, in the budget, \$3 million for psychiatrist loan repayment. What about Nurse Practitioner loan repayment to recruit and retain a cost effective work force? Nurse Practitioners have made invaluable contributions to the health care delivery system and outcomes in the nation. For these reasons, well-respected independent institutions such as the Institute of Medicine, the National Governors' Association, the Federal Trade Commission, AARP, the NYS Medicaid Redesign Team, and many more have all called for initiatives to increase the Nurse Practitioners in the work force.

How much of the budget has been spent on contracted MD's (locum tenens)?

Jail-Based Restoration to Competency:

One of OMH's efforts to shift patient care from OMH hospitals to the Department Of Corrections and Community Supervision facilities is not viewed as one that fully appreciates the mental health needs of the individuals who require mental health treatment. PEF, having several experts among its ranks who work for both OMH and DOCCS, believes that patients awaiting restoration to competency are best served when they receive services that are not found behind the razor fences of a jail or prison. Those who are best equipped to provide services that result in mental health stability and restoration to competency are found at the Office of Mental Health. Although it may be the case that many patients require repeat admissions to OMH hospitals while awaiting trial that is the nature of mental illness and not a legitimate reason to treat a patient in a jail or prison rather than in a psychiatric center. Every county in NY State is home to a jail that hosts a larger population of seriously mentally ill individuals. Rikers Island is one of the three largest providers of psychiatric care in the country (the other 2 are not hospitals or clinics, but jails: LA county jail in LA and Cook County Jail in Chicago).

Links to articles/documents below:

<https://www.omh.ny.gov/omhweb/planning/docs/507-plan.pdf>

<https://www.nytimes.com/2018/12/06/nyregion/nyc-housing-mentally-ill.html>

<https://nypost.com/2018/11/29/new-york-desperately-needs-more-mental-health-beds-not-less/amp/>

<https://www.nydailynews.com/new-york/n-y-mentally-ill-tragedy-article-1.3738567?outputType=amp>

https://www.washingtonpost.com/opinions/pete-earley-sending-the-mentally-ill-from-group-homes-to-an-uncertain-future/2014/10/30/f4bd84ce-5b22-11e4-8264-deed989ae9a2_story.html?noredirect=on&utm_term=.6225ea884ed9

<https://www.apnews.com/d4e0cc3dd2844237882b89267d9b2788>

<http://theconversation.com/violence-and-mental-illness-harsh-reality-demands-sensitive-answers-23460>

<https://www.freep.com/story/news/local/michigan/2018/09/21/grand-rapids-derin-stephens-roy/1377568002/>

<http://www.psychiatrictimes.com/blogs/jury-out-paid-peer-support-people-mental-illness>

<https://mentalillnesspolicy.org/blog.html/>

https://www.washingtonpost.com/opinions/dont-deny-the-link-between-serious-mental-illness-and-violence/2018/03/12/9705b17a-23ed-11e8-86f6-54bfff693d2b_story.html

<https://www.documentcloud.org/documents/5682677-Frontline-ProPublica-Letter.html>

<https://www.manhattan-institute.org/deinstitutionalization-mental-illness-new-york-state-city>

<https://www.nytimes.com/2019/01/23/nyregion/prisoners-mentally-ill-lawsuit.html>

<https://amp.cnn.com/cnn/2019/01/03/health/er-mental-health-patients-eprise/index.html>

<https://www.nytimes.com/2018/12/06/nyregion/nyc-housing-mentally-ill.html>

<https://www.nydailynews.com/opinion/shutter-island-rikers-fails-mentally-ill-article-1.3919307?outputType=amp>

<https://pix11.com/2018/02/24/rikers-and-city-jails-have-more-mental-patients-than-all-hospitals-in-nys-doctor-says/amp/>

<https://www.google.com/amp/s/nypost.com/2019/01/23/mentally-ill-inmates-suing-cuomo-over-extended-prison-times/amp/>



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Randi DiAntonio, Vice President

OPWDD

For the past six years, OPWDD has put forward a massive transformation agenda.

Some of these initiatives have had positive impact on various higher functioning individuals while others have resulted in residential and program closures. As a consequence, services and choices for individuals and their families have been diminished.

During this same timeframe, the OPWDD workforce has gone from 23,000 employees to just over 18,000. We are opposed to any more cuts to the workforce as these reductions; whether administrative or clinical, have a direct impact on the service system and individual care.

At present, there are few, if any, appropriate residential options available for newly referred individuals who need highly structured settings to stay safe. We should not have individuals languishing in hospitals, jails or unsafe situations in their family homes because there are no adequate placements available. We should not be placing our most needy in the “best” “worst” option.

PEF strongly believes that the professionals we represent are the clinical experts in the Developmentally Disabled field and that they should be the driving force of any transformation plan that aims to put the individuals at the center of care decisions. PEF members are more familiar with the needs of these individuals than any other provider anywhere in New York. While it is true that this year's budget includes an investment of \$120 million for OPWDD program priorities, including New Service Opportunities, you should know that all of it is for the development of private provider services. No money has been set aside for needed state operated opportunities. This is bad news for all New Yorkers as we are the safety net for the most vulnerable with the highest needs.

The Agency's long term plan to reduce the Specialized/Intensive Treatment beds to 150 has been realized despite the fact that the need for these types of specialized services still exists. We are now seeing a large increase in persons who are court ordered enter our delivery system because of their history and diagnosis of Intellectually Developmentally Disabled. Due to the closures, there are not enough resources to provide them services with the closure of most of the ITO's in NYS over the past six years. The voluntary providers we have been giving millions of dollars to have not developed any continuum of care for these vulnerable persons. The community continues to be concerned with where we place people with forensic

histories as it has been in the media statewide. PEF would like to see State Operations Clinical staff increased and a continuum of care for these individuals developed. We have a long history with assessing and treating this target population and would be well prepared now to develop more opportunities before our institutional knowledge as a workforce is contracted out. We continue to see individuals in our delivery system “stuck” in intensive treatment settings because there are no developed opportunities within the voluntary sector. We also see that persons that did get intensive services from the voluntary agencies are now being “returned” to state operations as a last resort after the enhanced funding ran out. We have seen first hand numerous examples of unsafe placement situations and shared our concerns with management and legislators alike. Unfortunately, our cries seem to have fallen on deaf ears. For whatever reason, there is an ill-advised, dangerous, and unrealistic drive to reduce this service in the OPWDD state delivery system without providing the necessary resources or residential development to ensure we can safely provide for people needing this level of specialized care.

The closing of the beds continues to negatively impact communities. We have seen high numbers of police calls, mental hygiene arrests and reports of service recipients being involved in significant police events.

Having said that, my colleagues and I have seen many positive changes during our careers in the delivery system, where people with developmental disabilities have moved from restrictive environments to situations that serve their needs in a less structured environment. Over the last five years, \$65 million has been provided in capital funding to expand independent living housing capacity. While we agree that this is a positive start, it is insufficient and does not identify or include any state operated opportunities necessary for us to develop this type of continuum for the individuals we serve.

PEF members are very concerned about the systemic failures and the reasons why they have occurred. We believe that while OPWDD is focused on and consumed with trying to transition state services to private providers, the recommendations of our dedicated and highly skilled members are often disregarded. This is done in order to meet the goal of getting the state out of the care business and into the oversight business. We believe the rush to transition puts the people we serve, the providers, and the communities in which they live in jeopardy.

The new resources in the budget focus on the access to services, affordable housing, managed care, minimum wage increases, but no new development opportunities specific to State Operations. We believe PEF Clinical professionals have an expertise

in working with persons with developmental disabilities in all areas from assessing risk, dining and eating skills, speech, physical and occupational therapy and can deliver those specialized services in a cost-effective way. We remain concerned that our expertise and knowledge will slowly fade without NYS investing in retention and recruitment commitment. The individuals we serve cannot get those specialty services from outside entities.

Bernard Fineson

We do appreciate that the budget supports OPWDD collaborating with OMH to develop a specialized transitional program for adults dually-diagnosed with developmental disabilities and behavioral health issues on the Bernard Fineson Campus in Queens. This initiative will support people who are discharged from an OMH certified inpatient setting, while they await access to appropriate OPWDD services in the community. PEF Supports this concept and believes this service model could and should be expanded to other areas of the state.

Justice Center

While we acknowledge and appreciate the positive changes that have been recently implemented at the Justice Center, we are still troubled by some of their practices that disrupt the overall functioning of OPWDD programs and imperil staff and

patients alike. PEF understands the importance of the Justice Center's mission and supports the thorough investigation of claims of abuse and neglect. That being said, procedural changes must be made to curtail the overzealous and aggressive (guilty until proven innocent) approaches that create serious recruitment and retention problems. Professionals constantly anxious that they will be brought up on frivolous charges that could end up costing them their careers are not likely to work for agencies under the Justice Center's purview. No one wins when staff is put out of work for an extended period of time. Disruptions to service recipients, increased mandatory overtime, emotional stress, trauma and financial hardship to individuals and their families are the result. We are asking the Legislature to support a comprehensive review of the Justice Center to assess its practices, effectiveness and efficiency and to identify opportunities for improvement.

IBR Blue Ribbon Panel

This years' budget continues funding for the Blue-Ribbon Panel reviewing the feasibility and logic of transitioning some or all operational components of the Institute for Basic Research in Developmental Disabilities (IBR) on Staten Island from OPWDD to the CUNY College of Staten Island (COSI). This decision would impact approximately 100 PEF members and we appreciate the ongoing dialogue and analysis before a decision is made. PEF supports IBR remaining under the auspices of

OPWDD, where it has been a tremendous success. PEF would like to see a much needed investment in the facility's aging infrastructure.

Managed Care and CCO's

This year's budget continues to support the transition from OPWDD's Medicaid Service Coordination program to a comprehensive care coordination model operated through several Care Coordination Organizations/Health Homes (CCO/HHs), the first step in the transition to managed care. Rather than focusing solely on coordinating OPWDD services, CCO/HHs will be responsible for integrating developmental disability, health, and other services into an individual's life plan to improve quality of life and other outcomes.

While we remain skeptical about the use of Medicaid Managed Care organizations or the initial Care Coordination Organizations, we conceptually support the idea of care coordination. It is unclear what role these external not-for-profit entities would have in state-operated group home settings and what the impact could be on the treatment team model.

The individuals we serve in our state homes have the most complex needs and tend to do poorly with change. CCO's do not have the established relationship with the

individual and may not understand the entirety of services or benefits available within state operations. As a consequence, individuals could be at risk of not getting the services that would be most beneficial to their individual needs. Having an outside entity serving as the care coordinator will increase gaps in communication and accountability. Accordingly, the knowledge and experience of the OPWDD provider and their ability to measure the quality and depth of the care coordination and services will be significantly compromised. Based upon the foregoing, PEF strongly contends that care coordination and assessment be provided by the state employees assigned to the regional office.

If the state provides the care coordination, the integrity of the system of service can be restored and maintained. The state will maintain a neutral, professional workforce of care coordinators who have no financial incentive to steer individuals into inappropriate or unnecessary care and will ensure that individuals get the service that they need. PEF believes exempting state-operated programs/facilities from having to utilize voluntary agencies for care coordination would be a small first step toward stabilization.

The initial rollout of the CCOs was not positive. Service recipients have had 3 or 4 in the first few months as the original CCOs didn't stay. The State "closed it out," adding no money or problem solving after the fall of 2018

We are asking that you slow down and apply common practice (run a pilot project) before you continue down this road any further. Moving forward with the transformation agenda without any of the necessary practical details for implementation has created widespread anxiety for individuals, their families and the state workforce.

Vehicles and Service Delivery

The miles driven by staff have tripled after the employment programs went into effect in 2013. Many of our current vehicles are over 12 years old, some as old as 19. Many have over 140,000 miles and are kept on the road until they can no longer pass inspection. More of the fleet will probably fail upcoming inspections in the spring. Vehicles are not being replaced at the rate we need them. We are expecting 40 new vehicles this year with a fleet of over 525 on the road.

Thank you for the opportunity to testify before you today.

The New York Times

Mentally Ill Prisoners Are Held Past Release Dates, Lawsuit Claims

The Green Haven Correctional Facility in Stormville, N.Y. A man being held there has sued the state, claiming he is being held past his release date because New York lacks sufficient housing for the mentally ill. Credit Edward Keating/The New York Times



By Ashley Southall

Jan. 23, 2019

On paper, a 31-year-old man found to have serious mental illnesses was released from a New York state prison in September 2017 after serving 10 years behind bars for two robberies.

But in reality, the man, who asked to be identified by his initials C.J., still wakes up each day inside a maximum-security prison in Stormville. Though he is technically free, he is still confined to a cell because of a Kafkaesque bureaucratic dilemma: The state requires people like him to be released to a supportive housing facility, but there is not one available.

Lawyers for C.J. and five other mentally ill men filed a federal lawsuit in Manhattan on Wednesday seeking to force Gov. Andrew M. Cuomo to address a shortage of housing for people with serious mental illnesses who need help adjusting to life outside prison walls.

The men are no longer being held in prison because they committed offenses, their lawyers argue, but because the state has determined they are likely to become homeless once released — a practice they contend amounts to discrimination under federal civil rights laws.

Four of the men, including C.J., have finished their maximum prison sentences and maintain their confinement also violates their constitutional rights to due process and protections against cruel and unusual punishment. The plaintiffs have asked the court to allow them to proceed anonymously because their lawsuit discusses sensitive personal information and they fear retaliation from prison guards.

Corrections records indicate the men are in “residential treatment facilities” — housing where residents are able to move about freely to seek jobs, visit family and pursue educational opportunities.

But the lawsuit says that label, as the state has applied it to 13 prisons, is a fraud, because the men are being held and treated as other prisoners are. They are locked in cells that have room for a bed and a few possessions. They are required to wear inmate uniforms. They cannot receive packages.

“Though labeled ‘releasees,’ they remain prisoners in every respect,” the complaint said.

The state continues to hold the men “because they are unable to secure a community-based mental health housing placement that does not exist due to lack of available beds,” the complaint said. In effect, the state has lengthened their incarceration, “undermining the most basic principle undergirding the criminal justice system: that a criminal sentence, once imposed by a judge, means what it says,” the lawsuit said

The lawsuit, which names the state corrections department and mental health office as defendants, was filed by the Legal Aid Society and Disability Rights New York, who are seeking class-action status on behalf of all inmates held in state prisons beyond their release dates solely because they are waiting to be placed in supportive housing.

It remained unclear on Wednesday how many mentally ill people were being held in prison past their release dates.

Jessica Riley, a spokeswoman for the state Office of Mental Health, declined to comment on the allegations in the lawsuit, but said the state has "one of the most robust supportive housing networks in the nation for individuals with mental illness," with about 44,000 units.

C.J. has been diagnosed with bipolar II disorder and antisocial personality disorder, court papers said. As his release date approached, he was enrolled in a re-entry program that was preparing him to be set free in Orange County, where he was looking forward to seeing his daughter for the first time since he went to prison. He had obtained a G.E.D. and a vocational certificate in prison and hoped to get a job.

But the day before he was scheduled to be released, C.J. was transferred to another prison, and later, to the Green Haven Correctional Facility in Stormville. His mental condition has worsened since his release date passed, and he has been repeatedly placed on suicide watch, according to the lawsuit.

"Every day is hard, very hard," C.J. said in written responses to questions from The New York Times. "I wake up and I look around and I don't understand why I am here."

The lawsuit does not seek an order requiring the six men to be freed. Rather, it asks that the state remove "the only barrier to their release" by creating more supportive housing for mentally ill people being released from prison.

The complaint cites a 1999 Supreme Court ruling in *Olmstead v. L.C.*, which held that public institutions must provide community-based services to people with mental illnesses who need and desire them.

For decades since the civil rights movement, public pressure had built on states to take mentally ill people out of psychiatric hospitals and place them in settings where they could participate in society, an effort called "deinstitutionalization."

But over the years, as psychiatric hospitals closed and lawmakers toughened crime and sentencing policies, more people with mental illnesses wound up incarcerated. Though prisons and jails developed treatment programs, few of them were effective, advocates for the mentally ill said.

About 4,000 people receiving mental health treatment in New York State prisons are released each year, and more than half of them have serious disorders like schizophrenia that severely limit their ability to function independently, according to the state Office of Mental Health.

Gov. Andrew M. Cuomo has committed the state to building 20,000 new supportive housing units, and state lawmakers so far have allocated \$2.6 billion to create the first 6,000 units by 2021.

But the lawsuit asserts that, under Governor Cuomo, the Office of Mental Health has neglected requests from counties across the state to build additional housing for former prisoners with mental disorders.

Such housing programs, where residents receive psychiatric care and learn skills like cooking and using mass transit, offer opportunities to participate in public life that prisons do not, mental health advocates say.

But waiting lists have grown longer as the state has eliminated beds from its psychiatric hospitals. The roughly 44,000 spaces available for the mentally ill are about half of what is needed, said Antonia Lasicki, the executive director of the Association for Community Living, which represents supportive-housing operators.

Despite the state's commitment to build more supportive housing, the creation of units has not kept pace with demand, and existing facilities are struggling to stay open, Ms. Lasicki and other advocates said. State funding "is barely enough to cover the rent," she said.

"So that's the problem right there in the nutshell," Ms. Lasicki added. "They're very underfunded."

A version of this article appears in print on Jan. 24, 2019, on Page A22 of the New York edition with the headline: Mentally Ill Inmates Are Imprisoned Past Release Dates. Lawsuit Says.

. New York

Estimated Prevalence of Severe Mental Illness in New York (2017)

Total adult population: 15.7 million

Individuals with schizophrenia: ~ 173,000

Individuals with severe bipolar disorder: ~ 345,000

(SOURCE: NIMH and US BUREAU OF THE CENSUS, 2017)

Mandatory Treatment Laws in New York

Like every state, New York has civil commitment laws that establish criteria for determining when involuntary treatment is appropriate for individuals with severe mental illness who cannot seek care voluntarily. New York's laws allow for the use of court-ordered treatment in the community, known as assisted outpatient treatment (AOT).

For inpatient treatment, a person must meet the following criteria:

- be a danger to self/others;
- have treatment in a hospital deemed essential, and
- be unable to understand need for care and treatment.

For outpatient treatment, a person must meet the following criteria:

- be unlikely to survive safely in community without supervision;
- have a history of noncompliance that includes two hospitalizations in past 36 months, or
- act/threaten/attempt violence to self/others in 48 months immediately preceding petition filing;
- be unlikely to voluntarily participate, needs in order to prevent relapse or deterioration likely to result in serious harm to self/others, and
- be likely to benefit from assisted treatment.

GRADING NEW YORK STATE LAWS

PART ONE: INPATIENT COMMITMENT STATUTE	26
PART TWO: OUTPATIENT COMMITMENT STATUTE	50
TOTAL	76
GRADE	C+

(SOURCE: GRADING THE STATES: AN ANALYSIS OF INVOLUNTARY PSYCHIATRIC TREATMENT LAWS, Treatment Advocacy Center, 2018)

Public Psychiatric Beds in New York

A minimum of 50 beds per 100,000 people is considered necessary to provide minimally adequate treatment for individuals with severe mental illness. Like every state, New York fails to meet this minimum standard.

Beds in 2016	Beds in 2010	Beds lost or gained	Beds per 100,000 people	Census of forensic patients	% of all beds occupied forensic	State ranking in beds per capita
3,217	4,958	-1,741	16.3	720	22.4	8

(SOURCE: GOING, GOING, GONE: TRENDS AND CONSEQUENCES OF ELIMINATING STATE PSYCHIATRIC BEDS, Treatment Advocacy Center, 2016)

Criminalization of Mental Illness in New York

Like every state in the nation, New York incarcerates more individuals with severe mental illness than it hospitalizes.

Total inmate population 2005	Estimated population of SMI inmates	Total psychiatric inpatient population 2004	Likelihood of incarceration vs. hospitalization
92,769	14,843	12,142	1.2 to 1

(SOURCE: MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A Survey of the States, Treatment Advocacy Center, 2010)

Criminal Diversion in New York

Criminal justice officials are responding to the criminalization of individuals with innovative programs designed to divert individuals with severe mental illness away from the criminal justice system. Two of the most promising programs are: mental health courts and crisis intervention training (CIT).

Percentage of population served by a mental health court	Percentage of population served by CIT	Combined average	Grade
75%	5%	40%	C

(SOURCE: PREVALENCE OF MENTAL HEALTH DIVERSION PRACTICES: A SURVEY OF THE STATES, Treatment Advocacy Center, 2013)

Policy Recommendations

- Stop eliminating public psychiatric beds
- Restore a sufficient number of beds to create access to inpatient care for qualifying individuals in crisis
- Make active use of the state's civil commitment laws to provide more timely treatment to individuals in need of treatment for symptoms of psychiatric crisis and reduce the consequences of non-treatment on them, their families and their communities

After Years in Institutions, a Road Home Paved With Hunger, Violence and Death

A housing ruling gave Nestor Bunch independence, with limited support. Was he ready?

By Joaquin Sapien, ProPublica Photos by George Etheredge, special to ProPublica December 14, 2018 This story was co-published with Frontline.

In September 2016, Nestor Bunch lay in a hospital bed in the intensive care unit at Long Island Jewish Hospital. One machine kept him breathing; another fed him through a tube. With the color drained from his face and a sheet drawn to his throat, he looked dead.

His doctors suspected an assault. Bunch, 54, had been hit hard enough to break three ribs. Skeletal muscle tissue was jostled loose into his bloodstream, causing his brain to seize and kidneys to fail. For the people who knew Bunch best — his therapists, his social workers, his family — the scene was as unsurprising as it was painful.

Diagnosed with schizophrenia, Bunch had spent most of his life under some form of supervision, whether in a group home or psychiatric hospital. He was prone to hallucinations so vivid, he taught himself to distinguish the real from the imagined by reading the reactions of those around him, as if asking, “Did you see that?”

Up until a few years ago, Bunch lived in an adult home — a privately run group home that houses people with disabilities including mental illness. Many such homes had been plagued by scandals of abuse and neglect. But a landmark 2014 settlement won him a chance at what promised to be a better life.

A federal judge ordered that residents of nearly two dozen New York City adult homes be given the chance to transfer into subsidized apartments under a program called scattered site supported housing, where people with severe mental illness could cook in their own kitchens, administer their own medication and budget their own expenses with support from private case management agencies.

Historically, supported housing was meant as a finish line for those who had demonstrated, under decreasing levels of supervision, that they could live alone. But the court order ushered a wave of adult home residents directly into a system in which people like Bunch were expected, overnight, to be able to care for themselves.

Last week, ProPublica and the PBS series Frontline published an investigation, in collaboration with The New York Times, showing how the sudden shift has proven perilous, even deadly, for those who were not ready to live with minimal support.

For this story, ProPublica and Frontline obtained about 7,000 pages of records from nearly every hospital, psychiatrist, social service agency and housing program that intersected with the lives of Bunch and his roommates, with permission. We interviewed dozens of mental health experts, therapists, family members, caseworkers and others about the quality and effectiveness of their care.

The state moved hundreds of people into the program without tracking their outcomes until this year. Bunch's story demonstrates the extraordinary fragility of some former adult-home residents and the limits of the support they receive.

The apartment where Bunch was found injured in Cambria Heights.

Bunch's mother, a small Colombian woman with an outsized personality, fought for his right to live on his own.

Elda Villamil was devoted, but overwhelmed by her son's early symptoms. He could break out into frightening outbursts. Records show he once punched a wall so hard that he broke his arm. He threw himself through a glass door and threatened her with a knife.

As Bunch bounced between psychiatric care and her home, she poured herself into the mission of the National Alliance on Mental Illness. She organized demonstrations, wrote to lawmakers, and even engaged in a yearslong correspondence with members of the Clinton administration, earning an invitation to both inaugurations, where she is seen in photos, beaming alongside Bill and Hillary.

Through her advocacy, she met a woman named Nora Weinerth, who would become a lifeline for Bunch.

Both women made helping people with mental illness find stable, independent housing, a top priority.

Their wish became real for Bunch for the first time in 2004. After years in and out of a psychiatric hospital, Bunch moved into a supported apartment with three other men. He stayed for five years, doing well for the first two. But, in time, he began to overwhelm his roommates, fighting and throwing out their belongings. He was hospitalized three times in a year.

The staff working with him there said in records that they were "unable to provide him with the supervision and monitoring he needs."

Bunch with Nora Weinerth, a close friend of his mother's.

And so, to the disappointment of his mother, he moved into the Queens Adult Care Center in 2009. Eight years earlier, when it was called Leben Home, the Times featured it in an investigation. Its residents had to be evacuated because the walls were crumbling. One woman died in a padlocked closet, from injuries sustained in a beating; another was raped by a janitor. At least a dozen residents had jumped off the roof.

Records from the adult home show Bunch ran into the occasional conflict there — he was once punched in the nose by another resident — but overall, he lived in a kind of malaise. He never got better, but never got worse. In therapy records from his time there, the phrase “no significant changes observed” appeared dozens of times.

Then, in 2014, people working for nonprofit housing providers showed up with brochures advertising clean, spacious apartments, offered as part of the court settlement with advocates, who successfully argued that most people in adult homes did not have to live under such restriction. If he took the opportunity, Bunch would no longer have to share a room or eat in a cafeteria where meals were universally loathed. He could listen to music as loud as he wanted. He could, as he always yearned for, find a girlfriend.

His mother was nervous about his second chance in supported housing, but also grateful. To her, the dullness of the adult home was broken up only by danger, she told her friend Weinerth. But she also knew that the staff at the home at least made sure he took his medication and kept his government benefits in relative order.

On Sept. 15, 2014, Bunch sat for a evaluation. In it, he said that he could use “mental telepathy to heal people from a distance” and that he felt “blue, because of all the skinny children.” He also said he wanted to “detox” from his medication.

Two nurses listened. “Expresses ideas without difficulty,” they noted. “Understands others” with “clear comprehension.”

His evaluation did not mention his previous failure in supported housing. It said he had been hospitalized up to three times over his entire life, not routinely, for 30 years.

But he met the minimum standards for supported housing as set forth in the court order: He was seriously mentally ill and lived in an adult home. The judge had ordered assessors to determine whether residents could live alone, and to start with the assumption they could. Except in cases where evaluators determined that people could be a threat to themselves or others, residents were supposed to be allowed to leave.

Bunch was approved for supported housing on Nov. 6, 2014. In the months leading up to his move, he had two more psychiatric hospitalizations. The first time, he told psychiatrists he “felt like a bug about to get sprayed by Raid.”

Bunch and several of his former roommates lived at the Queens Adult Care Center in Elmhurst, before moving into supported housing.

His therapist tried to warn the Institute for Community Living, the housing contractor helping with the move, that Bunch did not seem ready. "He has already been approved," an ICL clinical specialist said, according to therapy notes. "They can't wait any longer."

In response to questions, ICL officials said that they took multiple opinions into account, and that the person with the "least to gain or the least to lose was the independent assessor, who said he was ready to go." Ultimately, his psychiatrist judged him ready, ICL officials said.

In a last effort to prepare him, his therapist tutored him on his medication schedule. "He agrees to comply and expresses understanding," his therapist wrote. "But he also seems ... focused on getting a job such as becoming a surgeon."

Four days before he moved out, records show, Bunch said he stopped taking clozapine, a crucial prescription in his battery of antipsychotics.

Bunch moved into a studio underneath the passing planes of John F. Kennedy International Airport. From the edge of his bed, he could touch nearly everything he owned — his milk crates crammed with classic rock records; a television; amps; a stereo and an old guitar.

Records reflect a basic goal: to "remain in the community without ER visits, hospitalizations and/or returning to the [adult home]."

Two organizations would work with him: ICL, handling his housing, and the nonprofit Federation of Organizations, coordinating his medical care and other services.

Shaquan Young, an ICL "peer care coordinator" with the frame of a linebacker, would teach Bunch the basics: How to get to therapy sessions and clean his apartment. How to get to the nearest grocery store, where he urged Bunch to opt for the occasional vegetable over his preference for Twinkies and Ding Dongs.

But Young could not get Bunch to master his medication regimen, even after demonstrating how to divide doses into pillbox slots. Bunch wound up taking his morning pills at night, or vice versa, or not at all.

Records show that a clerical error caused Bunch's Social Security checks to be written in amounts smaller than he was entitled; they remained addressed to the adult home. Young got him an Electronic Benefit Transfer card and scraped together petty cash. It was never enough.

Bunch began to run out of food. When a social worker found only a bowl of sugar in his refrigerator, she took him grocery shopping, giving him \$20 and a list of nearby emergency pantries. When he was out of food 11 days later, Young brought him a meal and Bunch devoured it.

Bunch's stress intensified when he learned his mother had late-stage lung cancer. In December 2015, he entered his therapist's office, disheveled. "He agrees to call 911 or [go] to a hospital should he have suicidal thoughts," her notes said.

The next day, Bunch showed up at Elmhurst Hospital, twitching, showing doctors how he had clawed at his wrists. He said he'd tried to gouge his eyes out with a pen.

"He admits to feeling hopeless," a psychiatrist wrote, "and is worried about his rent arrears and having enough money to eat and maintain his new life."

Young still held optimism for Bunch's survival in supported housing. "We were just thinking, 'Okay, maybe he's just lonely.'"

Bunch moved into a cramped apartment above a jerk chicken restaurant in Jamaica, Queens, to live with Bernard Walker.

Walker, 54, had schizoaffective disorder and had been reliant on others for much of his life. "They thought he could be out on his own," said his 83-year-old mother, Rosetta Walker. "I said, I don't think so."

"Mr. Walker chose to move into the community after the fact several treatment providers suggested otherwise," an ICL worker wrote in his records, calling him "brave."

According to Young and others, the idea in pairing Walker with Bunch was that Walker was more functional. Records show he once held down a job as a sanitation worker. "If you have a roommate that's higher functioning," Young said, "you would probably follow that person's lead."

ICL leadership contested that notion. Its CEO said it tried to "match people's skills and abilities, rather than to take care of somebody else."

On Jan. 22, 2016, an ICL worker came to check on Walker; the forecast called for a blizzard, and she wanted to make sure he had food. Walker was not there, but Bunch let her in. She checked the refrigerator, then left.

Two days later, Bunch found his roommate dead.

The apartment that Bunch shared with Bernard Walker, 54, whom he found naked and dead in the foyer.

Walker was face down in the unheated foyer of their building, naked. Much of the city was covered in 2 feet of snow.

Neighbors recall seeing Walker days before he died, in his underwear, "practicing his karate" in the snow. Carmen Pacheco said he often banged on her door, begging for money and cigarettes. "I told him: 'Excuse me. Why don't you go inside, put on some clothes? You're going to get sick.'" Records indicate he showed up to a day treatment program wearing sandals in the middle of January.

The medical examiner concluded Walker died of cardiac arrest. Photos of empty pillboxes suggest he had been keeping up with his prescriptions.

Working with ProPublica and Frontline, Walker's mother and brother Michael, a retired New York City police officer, tried to obtain the results of a state investigation into the death. But officials said these documents are shielded by state law.

"It almost feels like they are trying to cover something up," Michael Walker said.

Two days after Bunch found his roommate dead, his mother died.

Bunch found Walker dead at the bottom of this staircase. They had lived together for just 16 days.

It fell to Young to deliver the news. Bunch showed little emotion, sitting glumly and talking about wanting a girlfriend. "Sometimes, I feel like there's something missing in my life," he said, according to records, "a wife, kids ... a family."

In the weeks that followed, Young saw him unravel anew. Bunch came to the door one day, bedraggled, murmuring to himself, according to records. He looked like he had lost weight and could not say when he last ate. His pillboxes were full. Young felt he had no choice but to get Bunch to commit himself to a psychiatric hospital.

Four days after he was discharged, Young found him in even worse shape, slurring his words, shivering, gulping tap water from an unwashed can of Chef Boyardee.

During a two-month hospital stay this time, his therapist, hospital psychiatrists and workers with two care agencies met. "It is agreed that he is not appropriate" for supported housing, his therapy notes show.

Bunch said he felt more comfortable moving back into an adult home, even if it was just temporary, "because he could always get his medications on time and he had lots of people around. He stated that he does not like to be alone."

Three days before he was discharged, he repeated his desire to either stay at the hospital or go back to the adult home. He also said that Hitler was alive and ruling Russia, and that it was only a matter of time before he attacked the United States.

Records are unclear about who made the final call. But Bunch was discharged to another apartment.

Bunch moved in with Eddie Lopez, who insisted in an interview that he was not mentally ill.

Lopez said he injured his leg in a knife fight when he was 15, and it got worse in prison, during a sentence he said he served for selling drugs. He was living in a homeless shelter when he learned that the Queens adult home had beds available for the physically challenged. He lived there for six years, until the opportunity arose to live in an apartment.

In a way, Lopez is a model for supported housing. He recycles cans and bottles, fixes bikes and appliances, and performs odd jobs for his neighbors. But the downside to his success, according to records and interviews, is that he has become a de facto home health aide for severely mentally ill roommates.

"Us that are functional are being used," he said, referring to the three roommates he has had to care for in as many years. "If it wasn't for me being here, who knows what'd happen?"

When Bunch showed up at a schoolyard, leering at children, neighbors asked Lopez to take him away. "He thought he was a kid," Lopez said. "I had to explain to him, 'No, you don't do that.'"

When Lopez came home to a blaring fire alarm, empty pots burning on the stove, he realized he had to start cooking for Bunch.

Eddie Lopez outside the apartment he shared with Bunch on Union Turnpike in Queens.

Records show the apartment had plumbing problems. Lopez said the toilet wouldn't flush, so he found a solution: a bucket, filled with water, to pour down the bowl. Bunch couldn't figure it out, and the apartment soon "smelled like defecation," Lopez said.

On Young's visits, Bunch came to the door shirtless, screaming expletives. He told his therapist he did not "like his medication because it looked like rocks."

The arrangement went on for five weeks. Lopez grew "very frustrated," according to Young's notes, telling him, "I don't want to be someone's home attendant."

Young said he and his superiors worried Lopez would complain to the state. ICL disputes this, saying he was moved only because of the plumbing issue. Regardless of motivation, Bunch wound up in another apartment, with yet another roommate.

This time, he moved into a brick duplex on the border of Jamaica and Cambria Heights, Queens, with a 67-year-old Guyanese immigrant named Jagnanan Ramnanan.

For 17 years, Ramnanan, who had a diagnosis of paranoid schizophrenia, had lived in the Queens adult home, where his peers elected him to run the residential council. He was gregarious and often donned a fedora, tie and jacket.

But records show he was also an alcoholic and a repeat presence at Elmhurst Hospital. Sometimes, he came in for head injuries sustained while drunk; other times, because his caretakers feared alcohol poisoning. A girlfriend at the home once alleged he punched her in the face, his adult home records show.

Reached by ProPublica and Frontline, his estranged wife said she filed multiple orders of protection against him. She said he once damaged cartilage in her nose and face. "He can hurt you," she said. "And then, he can take care of you."

By the time he and Bunch moved in together, Ramnanan had been kicked out of an apartment where he'd spent just a few days. His landlord "worried he may burn down the house," according to ICL records. She had found him drunk, the apartment thick with cigarette smoke, the fire alarm screeching.

That fall of 2016, Bunch came under the care of a new Federation worker, his fourth in 18 months. Between the time that she started and his last worker quit, a full month had gone by. Records show she called him repeatedly on Sept. 6, but he wasn't picking up. She arrived at his apartment that day to find keys hanging from the door. She rang the bell, then yelled through an open window.

Finally, Ramnanan told her he had found Bunch on the floor in the middle of the night, having a seizure, and called an ambulance. She went into Bunch's room and saw his mattress had been knocked off the box spring. Ramnanan could not explain why.

Doctors in the intensive care unit at Long Island Jewish Hospital suspected Bunch had been beaten. The muscle damage was so severe, one doctor thought he could have suffered for days before he received medical attention.

To Weinerth, he looked like a "cadaver." She had sworn to his mother, on her deathbed, that she would watch out for Bunch. Now, with doctors telling her he had been attacked, "I felt a certain bitter relief that she wasn't alive anymore to witness it," Weinerth said.

Records show a doctor told the caseworker he wanted to speak with Bunch's roommate. But in hundreds of pages of documents, there is no record showing anyone questioned Ramnanan. Bunch's therapy notes reference an "incident report" made to "the state," but records from his three primary providers do not include evidence of follow-up.

While Bunch was in the hospital, Ramnanan was found in his apartment by a worker for his old adult home who had been searching for a missing friend of his, known to drink with him. They were both drunk; Ramnanan was unconscious. A pot of food was burning on the stove.

Ramnanan was taken to the hospital but died eight days later of complications related to liver failure.

"My roommate died, my mom died and he died," Bunch told me, referring to Ramnanan. "That's a hell of a lot to go through."

Bunch sat across from me one brisk night last year in a Brooklyn pizzeria. When we met, he spoke in loops so inscrutable, I asked to see identification to be sure it was him.

He could not remember his social workers or the names of roommates. He thought he had lived at the Queens adult home for months, not years. He was as likely to answer a question about what he had for breakfast with a fantasy of becoming an orthopedist as he was to say something like "Froot Loops."

That is not to say he could not recall vivid memories: Finding one roommate "frozen" in an "embryo position" and "totally naked." "The Hindu man" who drank a lot and watched films about cowboys and Indians.

He later said that he doubts Ramnanan could hurt him but remembers an argument about cleaning, and that Ramnanan was "dancing" on top of him just before he awoke in the hospital. (Ramnanan's family also doubts he was capable of the attack, because he was so physically weak at that point.)

From documents, we pieced together that, during months in rehabilitation, several social workers and case managers once again voiced concerns about Bunch's ability to live independently, but he was returned to his dead roommate's apartment anyway.

"There were beer bottles, cigarettes. The floor was dirty," Bunch said.

ICL determined he should stay somewhere else while the apartment was cleaned. He finally wound up at the kind of facility his therapists and social workers had long been discussing: Level II housing, with 24-hour staff, medication management, three meals a day and therapeutic services. These kinds of beds were limited, and Bunch first had to fail out of the care he had.

The stay was supposed to be temporary, but just eight days in, he was found by police, wandering the streets on a freezing night in January 2017, hypothermic, dehydrated and delusional. A hospital psychiatric nurse gave him an evaluation that summed up what so many had said for so long:

"Nestor Bunch requires constant behavioral supervision and medication management, which he cannot perform for himself. ... He cannot perform any activities of daily living without support, which would not be available in a less restrictive setting."

In August, we presented all we had learned about Bunch to David Woodlock, the chief executive officer for ICL, which had been the most consistent presence throughout Bunch's time in supported housing.

The exterior of Stepping Stone, an Institute for Community Living group home in Downtown Brooklyn where Bunch lived.

Woodlock acknowledged that Bunch had taken a number of "enormous whacks," but said that ICL went "above and beyond" its "contractual obligations" with Bunch when it came to things like helping with his Medicaid benefits. He explained that, technically, ICL was responsible for little more than housing him.

He said that Bunch's treatment was primarily under the domain of his "Health Home," the Medicaid program that organizes his plan of care. That agency, Northwell Health, said it left it to its subcontractor, Federation of Organizations, to report any incidents and handle care coordination. With Bunch's consent, Federation supplied 381 pages of his case management notes. It would not share documents related to the care of Walker or Ramnanan unless the families could prove they had been previously authorized to make health care decisions for the two men.

Later, ProPublica and Frontline sent Federation a 10-page letter with more than 60 questions about the cases of Bunch and his roommates, and the organization's involvement in the settlement.

In a five-page response, the organization would not answer questions about specific cases, saying it was limited because of health privacy laws, but it noted that the two deaths were "not caused in any way by the provision of services provided." Federation said people are only moved into supported housing by their own choice, and only after they have been assessed and deemed ready.

Joseph Buzzell, an attorney representing the organization, said Federation reviewed its records and determined that it had not "violated any of its duties to provide service." He said that "incident reports were filed and submitted to necessary entities," but that such reports were not in the documents provided because state law required them to be housed separately.

After months of questions from ProPublica and Frontline, Bunch's case surfaced at a hearing on the implementation of the settlement last week. Clarence Sundram, the independent court monitor installed to oversee the transition, cited this case to show the kinds of episodes agencies will now have to report to the state, which will investigate and analyze them for corrective actions. Up until recently, there was no such incident tracking system for things like unsafe and unsanitary living conditions and repeat crisis episodes, including two or more psychiatric hospitalizations within a year. U.S. District Judge Nicholas Garaufis ordered a report on the tracking system's effectiveness in response to the investigation by ProPublica and Frontline published last week.

Read More: Living Apart, Coming Undone

Under a landmark settlement, an ambitious housing program promised a better life for mentally ill New Yorkers. But some of the most vulnerable slip through the cracks. [Read the story.](#)

In a statement, Office of Mental Health officials said that though the vast majority of former adult-home residents are doing well in supported housing, they recognize “there are very few cases in which class members were ultimately unable to thrive in an independent setting, were negatively impacted by their transition, or have decompensated since moving to the community. For these class members, the State is focused on continuing to improve its systems of care and ensuring there are no gaps in service so that issues and concerns may be addressed in real time for the maximum benefit of all class members.”

Officials said they have put an additional \$10 million into staffing and training and stepped up payments to housing providers for new residents.

The Department of Health denied a Freedom of Information Law request for any records related to Bunch’s injury, citing privacy restrictions. The Office of Mental Health also denied such a request. Officials said the records are shielded by state law.

As for Woodlock, he referred to Bunch’s final injury as a “medical crisis,” which ICL had no obligation to report to the state. “If you assume it’s an assault, there’s a certain pathway. If you assume it’s a medical crisis, it’s kind of another pathway,” he said.

Beyond reviewing Bunch’s rehabilitation records, he said ICL did not investigate. “I don’t know that any of us have a conclusion, a firm conclusion, about what did or didn’t happen.”

Ultimately, Woodlock said Bunch’s housing came down to the decisions of one person above all others: Bunch himself. He referred to the concept as the “dignity of risk,” allowing people with mental illness to choose where they live except under extraordinary circumstances, even if they might fail.

“Could many of the sad things that happened to Nestor have happened if he was in a 24-hour supervised setting?” Woodlock asked. “Yeah, I think they could have.”

We learned that in the days prior to the interview, Woodlock and other ICL executives had taken Bunch to lunch. ICL officials say they did so as a courtesy, to gain his perspective and better inform the interview. It was around that time that his life had begun to dramatically change.

By then, he had moved into another ICL apartment in the Lefferts Gardens section of Brooklyn. He has a new roommate now, 41-year-old Jeanne Satchell, whom he calls a “sweetheart.” He also has an aide for several hours per day. From nearly his first day in supported housing, his providers knew he needed one, but a holdup with his Medicaid benefits left him without one for years.

Bunch and his current roommate, Jeanne Satchell, 41.

Alma Bravo, a 27-year-old mother of two, buys his groceries, does his laundry and takes him around town. He has been to Ripley's Believe It or Not in Times Square and the New York Aquarium on Coney Island.

But the support he is getting is not meant to be permanent.

He is now in what is called a Treatment Apartment Program. On average, the program costs about \$48,000 a year, split between state and federal funds. This is almost double the average price tag of what he was getting before, in supported housing. Only eight former adult-home residents out of the 764 who have transitioned as of mid-November are in a treatment apartment, according to state officials.

But, like any Level II program, treatment apartments are meant to be transitional, and residents are eventually supposed to move back into a more independent situation with fewer services.

For now, it is clear how much Bunch relies on Bravo. When she was out sick for just two days in early October, she returned to find Bunch struggling. He was hallucinating, laughing to himself and clapping to music no one could hear. He had not eaten. The refrigerator was empty, except for frozen meat. He had run out of money and complained of an excruciating toothache.

Bravo said she was skeptical he could live by himself again. "Who's going to cook for him?" she asked. "Who's going to remind him of his appointments?"

She looked up an urgent care dental clinic, and together, they set out.

Tom Jennings, Kate McCormick, and Nicole Reinert contributed reporting. Frontline and ProPublica are working together on an upcoming documentary.

Joaquin Sapien has covered mental health, social services, criminal justice and other subjects for ProPublica since 2008.

Design and production by Hannah Birch and Aunes Chang.
