NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Michelle Morse, MD, MPH
Acting Health Commissioner

Testimony

of

Dr. H. Jean Wright II
Executive Deputy Commissioner for the Division of Mental Hygiene
New York City Department of Health and Mental Hygiene

before the

New York City Council

Committee on Mental Health, Disabilities and Addiction

On

Oversight: Evaluating DOHMH's Systems for Measuring Outcomes and Equity in City-Funded Mental Health Programs.

December 17, 2025
250 Broadway, Hearing Room 1
New York, NY

Good afternoon, Chair Lee and members of the Committee. I am Dr. Jean Wright, Executive Deputy Commissioner for the Division of Mental Hygiene at the New York City Department of Health and Mental Hygiene (the Health Department). I am joined today by Jamie Neckles, Assistant Commissioner for the Bureau of Mental Health, and Dr. Rebecca Linn-Walton, Assistant Commissioner for the Bureau of Alcohol and Drug Use. Thank you for the opportunity to testify today.

The Health Department recognizes that mental health and well-being are central to overall health. The Mental Health Division puts this into action by employing a public health approach to supporting the mental and behavioral health of all New Yorkers. We serve as the City's mental health strategist and work with more than 200 community providers to deliver over 800 mental health programs.

First, I'd like to share our vision for mental health for New York City, which shapes our desired outcomes, divisional strategy, and day-to-day operations.

A public health approach to mental health aspires to a future where every single New Yorker lives with dignity and meaning. Everyone has access to the resources they need to thrive and live to their full potential. New Yorkers understand the importance of mental health, have access to services they need, and know how to access them. Where New Yorkers are free from stigma, oppression, and the consequent health disparities.

The Health Department is organized around this ultimate vision. I want to uplift what Acting Health Commissioner Dr. Morse shared in her recent testimony on HealthyNYC, the city's campaign for improving life expectancy. Most New Yorkers did not live to see their 50th birthday when the Health Department first started calculating life expectancy in the early 1900's. Today, our latest data shows that NYers can expect to live into their eighties. Transformation has happened and remains possible, especially when there's support for public health infrastructure.

I'll now turn to our work today in the Mental Health Division.

The Health Department is the City's mental health strategist. We stand at the nexus of the city's mental health system - serving as a linkage between the State, the City, hospitals, providers, peers, communities, and experts. We provide decision makers, and the public, with population health data on mental health outcomes, paired with guidance and collaboration in acting on it.

First and foremost, we look to health outcomes to measure the wellbeing of our communities and inform program strategy.

For example, HealthyNYC identified key drivers of life expectancy, including two mental health outcomes: suicide deaths and drug overdose deaths. The Health Department developed ambitious goals to reduce both drivers and closely monitor progress in these outcomes.

Suicide is one of the top 10 leading causes of premature death. After a slight reduction in the suicide rate in 2018 to 2019, rates climbed during the COVID-19 pandemic. Provisional data for

2023 and 2024 show a slight decrease (a 2.5% decrease compared to 2021) showing a return to previous levels. Overall, suicide rates remain mostly level over the long term. We are committed to our goal of reaching a 10% reduction by 2030.

Regarding overdose, our most recent data shows progress with a reduction in drug overdose death. Following years of increases that cost New York City nearly 20,000 lives since 2016 – the number of overdose deaths decreased by 28% in 2024. Residents of all five boroughs saw decreases. While significant racial and geographic inequities persist, overdose deaths decreased among Black and Latino New Yorkers for the first time since 2018.

This information is essential for understanding the health of NYers and guiding our programmatic investments.

Our mental health programs are diverse, ranging from direct services to systems change interventions. We identify unique outcomes for each program to measure service quality, impact, and successful program implementation.

For example, the Intensive Mobile Treatment (IMT) program was created almost 10 years ago because we saw an unmet need and responded with innovation. IMT serves individuals with high service needs that are not being met in traditional mental health outpatient settings. IMT consistent of teams working in the community to provide long term support to people with serious behavioral health concerns and complex life situations that may include transient living situations and housing instability and/or involvement in the criminal legal system.

Stable housing is a program outcome we monitor in IMT because many referred individuals are unhoused at the time of enrollment. In FY25, the proportion of those stably housed increased by 23% between the first and most recent year of enrollment.

Individuals referred to IMT also often have a history of involvement in the criminal legal system, so this is another key program outcome we monitor. IMT teams provide support to prevent participants' further involvement. Among IMT participants served in FY25, the proportion of those with jail admissions in the NYC Department of Correction system decreased by 5% between pre-enrollment and the most recent year of enrollment.

If we look at supportive housing, the program outcomes are different. The mission of supportive housing is to provide dignified, safe and affordable housing as a platform for health and recovery. While we monitor aspects of service quality and tenant outcomes, the number of supportive housing units available in itself is a critical program outcome. We currently contract for **12,817 units** of supportive housing and are on track for 13,000 units by the end of the calendar year.

Lastly, I'd like to highlight the Outreach and Syringe Litter Teams. These teams conduct outreach to people who use drugs in public in order to provide naloxone and connect people treatment, health care, and resources to meet their basic needs. They also respond to community concerns of syringe litter. There are currently 6 teams, operated by 5 contracted Syringe Service

Providers. In 2024, these teams cleaned up and safely disposed of more than 199,000 syringes, initiated over 25,500 participant engagements, and made more than 8,000 referrals to additional care services. To expand on this work, soon all 16 Syringe Service Providers in the City will have Outreach and Syringe Litter Teams.

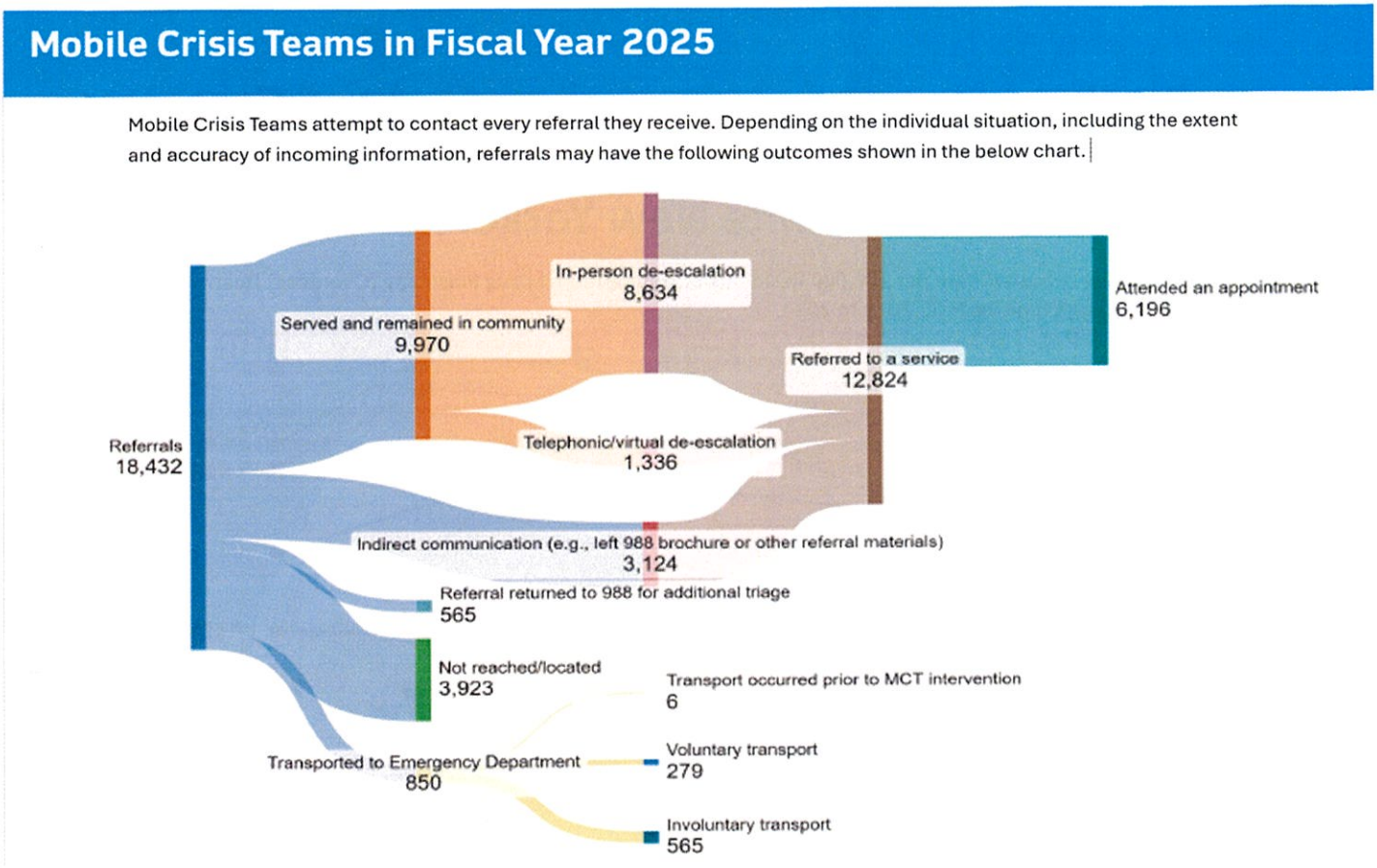
I've highlighted a handful of the 800+ mental health programs we support to illustrate the thoughtful, evidence-based approach to measuring success we employ for each unique program.

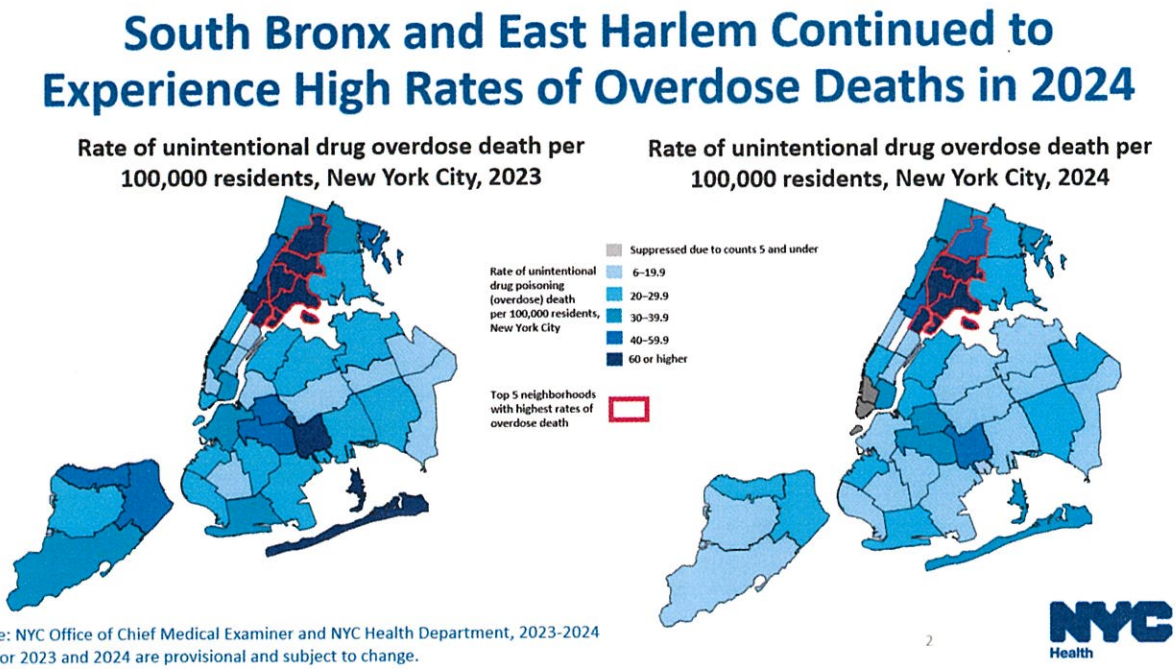
Across all programs, equity is always a critical consideration and desired outcome. Health equity is central to our vision for mental health in the City. We recognize that historic and contemporary injustices in government, health care, and other institutions have deepened distrust and contributed to individual and collective trauma, while exacerbating inequities across health conditions. We aim to eliminate inequities in mental health outcomes. The Health Department is dedicated to supporting the mental and behavioral health of ALL New Yorkers.

I am proud to share these impressive outcomes today and pleased with the progress we have made. We look forward to continually improving our programs, expanding our partnerships, and enhancing our supports for NYers in the greatest need. We welcome feedback from Council and community members today as we continue to improve and adapt the City's mental health infrastructure to better meet the needs of New Yorkers.

Thank you for the opportunity to testify. My colleagues and I look forward to answering your questions.

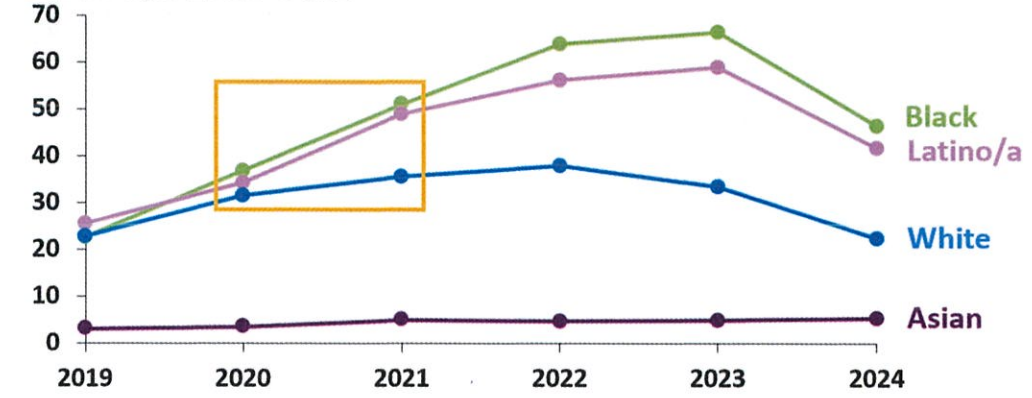
Appendix


Mobile Crisis Teams in Fiscal Year 2025
Mobile Crisis Teams attempt to contact every referral they receive. Depending on the individual situation, including the extent and accuracy of incoming information, referrals may have the following outcomes shown in the below chart.
Referrals
18,432
Served and remained in community
9,970
In-person de-escalation
8,634
Telephonic/virtual de-escalation
1,336
Indirect communication (e.g., left 988 brochure or other referral materials)
3,124
Referral returned to 988 for additional triage
565
Not reached/located
3,923
Transported to Emergency Department
850
Referred to a service
12,824
Attended an appointment
6,196
Transport occurred prior to MCT intervention
6
Voluntary transport
279
Involuntary transport
565


South Bronx and East Harlem Continued to Experience High Rates of Overdose Deaths in 2024
Rate of unintentional drug overdose death per 100,000 residents, New York City, 2023
Rate of unintentional drug overdose death per 100,000 residents, New York City, 2024
Rate of unintentional drug poisoning (overdose) death per 100,000 residents, New York City
Suppressed due to counts 5 and under
6–19.9
20–29.9
30–39.9
40–59.9
60 or higher
Top 5 neighborhoods with highest rates of overdose death
Source: NYC Office of Chief Medical Examiner and NYC Health Department, 2023-2024
Data for 2023 and 2024 are provisional and subject to change.
NYC Health

Black and Latino/a New Yorkers Had the Greatest Increases and Slower Decreases Compared to White New Yorkers

Age-Adjusted Rate per 100,000 Residents of Unintentional Drug Poisoning (Overdose) Death by Race/Ethnicity, NYC, 2019 to 2024



Source: NYC Office of Chief Medical Examiner and NYC Health Department, 2019-2024
Data for 2023 and 2024 are provisional and subject to change.

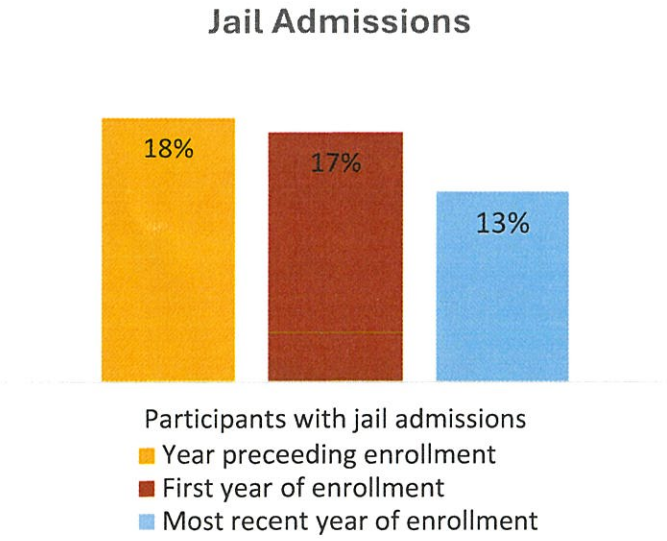
NYC Health

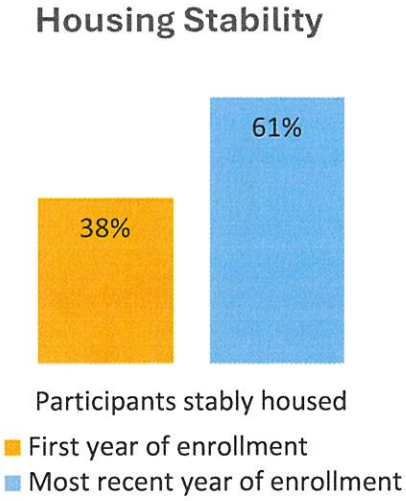
Mental Health Programs in Fiscal Year 2025

SPOA Capacity in FY25

At the end of FY25 (as of 6/30/2025), there were **69 ACT teams, 6 FACT teams, 10 SPACT teams, 36 IMT teams**, and **26 NMCC providers** in NYC. The capacity of each service type is shown below.

Intensive Mobile Treatment (IMT) Outcomes in FY25



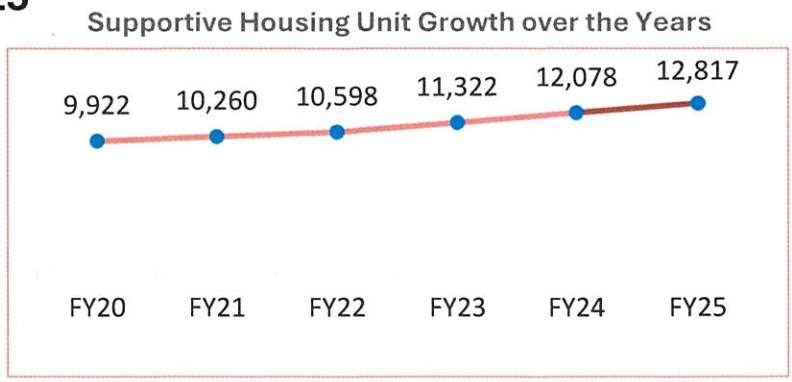


Supportive Housing Growth in FY25

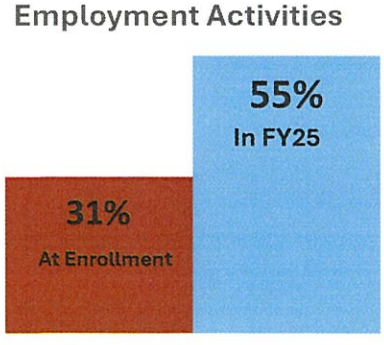
This chart reflects the growth in DOHMH-contracted supportive housing units over the last six fiscal years.

Average length of residence is

7.6 years



Clubhouses in FY25



Testimony on Outcomes Measurement and Equity in City-Funded Mental Health Programs

Paula Magnus, Deputy Director
Northside Center for Child Development, Inc.
December 17, 2025
Committee on Mental Health, Disabilities and Addiction – Chairperson Lee

Thank you, Chairperson Lee and esteemed Committee Members, for convening this important hearing on outcomes measurement and equity in city-funded mental health programs.

Good afternoon. I am Paula Magnus, Deputy Director of Northside Center for Child Development. For over 75 years, Northside has provided comprehensive mental health services to children and families in Harlem and beyond.

We operate the following programs with the NYC Department of Health and Mental Hygiene (**DOHMH**):

1. **City Council-Funded/DOHMH-Regulated Programs:**
    - **Court Involved Youth Initiative** (serving 40 high-risk adolescents annually).
    - **Children Under Five Initiative** (providing early intervention).
2. **DOHMH Direct Contracts:**
    - **Early Intervention**
    - **Home Based Crisis Intervention program.**
    - **Special Needs Unit**.
3. **DOHMH Licensed Programs:**
    - Three **Head Start/Early Head Start** programs - located in East Harlem, Brooklyn, and the Bronx.

We commend DOHMH for their thoughtful oversight of our programs and appreciate the Council's leadership in examining how we can collectively strengthen outcomes measurement across city-funded mental health services.

Our Experience with Systematic Measurement

Based on our direct experience serving vulnerable children and families, we'd like to offer some observations for the Council's consideration.

Tracking treatment contacts has proven valuable in our work with children. For children under five, consistent therapeutic contact builds the secure attachment that evidence-based interventions require. For court-involved youth, we've observed that maintaining regular contact often correlates with better engagement and outcomes.

Regular outcome assessment using validated screening tools helps us adjust interventions based on data alongside clinical judgment. In our experience, this approach allows us to identify when youth need additional support before situations escalate.

Data quality practices help ensure accuracy when child welfare, family courts, and schools rely on provider reports to make critical decisions about children. In our programs, supervisory review of clinical documentation supports both quality care and program integrity.

Equity Considerations

We appreciate the Council's focus on equity in service delivery. Based on our experience, we believe equity measurement across multiple dimensions—including race, ethnicity, language, immigration status, and geography—could help identify where certain populations may face barriers to accessing services or achieving positive outcomes.

The Value of Standardization

We encourage the Council to work with DOHMH to establish standardized outcomes measurement systems across all city-funded mental health providers. We believe DOHMH is well-positioned to define core metrics, provide training, and ensure consistency, while providers implement these tools with populations we know best.

Standardized systems would enable:

- Tracking treatment contacts to ensure consistent engagement
- Regular outcome assessment using validated tools across all programs
- Data quality practices that support accurate reporting
- Disaggregated equity reporting to identify and address disparities

What Implementation Would Require

For providers to implement these standardized systems effectively, adequate funding is essential in three areas:

Data infrastructure: Electronic health record systems that efficiently track contacts, outcomes, and demographics across all providers require significant investment. For our

peers in the industry, we'd like to note that Northside uses Netsmart myEvolv as our electronic health record system. Clinicians enter process notes, assessments, diagnoses, and outcome metrics directly into myEvolv. We complement this with Microsoft SQL Server to pull from the database and generate reports, and Power BI to provide clinicians and supervisors with real-time visibility into productivity and outcomes. This integrated approach has enabled us to maintain consistent data quality while supporting clinical decision-making.

Staff capacity: Data collection and quality assurance require dedicated time. Full-cost funding that accounts for supervision and data management is necessary for providers to maintain robust systems.

Training and technical assistance: Resources for DOHMH to provide standardized guidance on measurement tools and protocols would promote consistency across city-funded programs while respecting each provider's expertise with their populations.

Our Request

We encourage the Council to work with DOHMH to establish standardized outcomes measurement systems across all city-funded mental health providers. We believe DOHMH is well-positioned to define core metrics, provide training, and ensure consistency, while providers implement these tools with populations we know best.

We hope the Council will consider supporting disaggregated equity reporting as part of these standardized systems, along with funding that enables providers to implement these requirements effectively. Standardized measurement can demonstrate that City Council investments in mental health produce results, but only if providers have the resources to do this work properly.

We're grateful for the Council's continued investment in mental health services for New York's most vulnerable children and families, and we appreciate DOHMH's partnership in delivering quality care.

Thank you for your time and consideration.

ASIAN AMERICAN MENTAL HEALTH ROUNDTABLE
Collective Care for Our Communities

Testimony to the New York City Council
Committee on Mental Health, Disabilities, and Addiction
December 17, 2025

Thank you, Chair Linda Lee, and members of the Committee on Mental Health, Disabilities, and Addiction, for holding this hearing and providing us with the opportunity to testify. I am Sofina Tanni, and I am the Senior Program Coordinator at the Asian American Federation. We are here today testifying as part of AAF's Asian American Mental Health Roundtable, a coalition of 15 Asian-led, Asian-serving organizations that collaborate to address challenges, create solutions, and share resources to increase access to culturally competent mental healthcare.

Current Mental Health Landscape for Asian American New Yorkers

Asian New Yorkers are experiencing increasingly complex mental health challenges shaped by intersecting social, economic, and structural factors. Asian Americans have the greatest ethnic diversity among major racial groups due to their varied national origins and homeland identities, reflected in the more than 40 languages and dialects spoken across New York City's Asian communities, making it essential that mental health evaluation systems account for this diversity.[1] Of the 1.5 million Asian New Yorkers, 66% are foreign-born, 15% live in poverty, and 44% have limited English proficiency.[2] Additionally, 26% of Asian Americans nationally have limited digital skills, further limiting access to telehealth and online mental health resources.[3]

Our Asian American Mental Health Roundtable partners serve a wide range of ethnic communities—including Afghan, Bangladeshi, Cambodian, Chinese, Hmong, Indonesian, Indian, Indo-Caribbean, Japanese, Korean, Laotian, Middle Eastern, Nepalese, Pakistani, Taiwanese, and Sri Lankan New Yorkers—across varied ages, income levels, and immigration statuses. These differences shape how mental health challenges are experienced and how services are accessed.

Providers report that many clients are navigating multiple, overlapping stressors at once, including trauma, domestic violence, family and intergenerational conflict, housing instability, food insecurity, and economic precarity. These conditions significantly affect mental health outcomes and often require sustained, culturally responsive, and trauma-informed support. This landscape underscores the need for evaluation systems that reflect the lived realities of Asian American communities and the complexity of care required to support them.

Current Gaps in Measuring Mental Health Outcomes for Asian Communities

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[1] Asian American Federation. Asian Languages in New York City. July 30, 2022. Accessed December 19, 2025. https://www.aafederation.org/research/asian-languages-in-new-york-city/
[2] Asian American Federation. Homepage. AAF Data Center. May 1, 2024. Accessed September 13, 2024. https://datacenter.aafederation.org/.
[3] National Skills Coalition. Applying a racial equity lens to digital literacy. Accessed September 13, 2024. https://nationalskillscoalition.org/wp-content/uploads/2020/12/Digital-Skills-Racial-Equity-Final.pdf.

When evaluating City-funded mental health programs, DOHMH must recognize the importance of both quantitative and qualitative data. While numerical metrics, such as the number of individuals served or sessions delivered, help measure program reach, they do not capture the depth, intensity, or effectiveness of services provided to communities facing layered barriers to care.

Roundtable providers consistently report an increase in the severity and complexity of mental health needs among Asian New Yorkers. Addressing these needs requires time-intensive, relationship-based, and culturally competent care, particularly when stigma and distrust of formal systems delay help-seeking. For many clients, meaningful progress may involve gradual trust-building, improved family communication, or increased willingness to engage with services, outcomes that are not reflected in standard numeric reporting.

Qualitative measures such as narrative progress, reductions in stigma, strengthened support systems, and sustained engagement are critical indicators of success. These outcomes reflect the real-world impact of services, as well as the staff time, cultural expertise, and emotional labor required to deliver them. Without incorporating these measures, evaluation systems risk undervaluing community-based mental health work and misrepresenting program effectiveness.

Structural Barriers Affecting Mental Health Service Delivery

Several structural challenges directly affect how mental health programs serving Asian communities are evaluated and understood. Asian-serving organizations report high staff turnover driven by low nonprofit salaries and limited professional development opportunities. Rigid funding structures often prevent organizations from investing in retaining culturally and linguistically competent staff with institutional knowledge. As a result, evaluation systems may misinterpret staff turnover or fluctuating service delivery as program underperformance, rather than as a symptom of underinvestment in workforce sustainability. As roles are filled, newer nonprofit staff must learn their new position responsibilities, evaluation methods, and city processes and requirements. Institutional knowledge is lost with staff turnover, and it takes a significant investment of time and resources from organizations to upskill new staff members.

Additionally, non-clinical mental health services play a critical role in stigma reduction, trust-building, and early intervention, but are often not recognized as valid forms of mental health care, despite being an entry point into clinical mental health services and addressing social determinants of health. Because these services do not always align with traditional clinical metrics, their impact is often excluded from evaluation frameworks, influencing organizations' ability to seek dedicated mental health funding and demonstrate program reach.

Finally, limited administrative and evaluation capacity among smaller, Asian-led organizations affect how outcomes are reported and measured. Many organizations lack sufficient technical assistance to support data collection, qualitative evaluation, or compliance with complex reporting requirements. Without targeted capacity-building, these organizations are at risk of

being disadvantaged in evaluation processes. This is not due to a lack of impact, but due to systems that fail to account for their size, resources, and community-based models of care.

Together, these barriers highlight the need for evaluation systems that are flexible, context-aware, and equity-centered, ensuring that programs serving immigrant and linguistically diverse communities are assessed fairly and accurately.

RECOMMENDATIONS

Based on our mental health expertise and the voices of our Roundtable partners, we urge the Council to consider the following:

1. Incorporate equal emphasis on qualitative outcomes when assessing program success, not just numerical outputs.
2. Evaluate programs based on depth of support, especially for immigrant communities facing cultural, linguistic, and systemic barriers.
3. Reduce reporting requirements to allow organizations to dedicate more staff time to direct services, especially for communities requiring trauma-informed and time-intensive support.
4. Provide a transparent outline of how program success will be measured, including required outcomes, reporting expectations, and evaluation metrics. This will help organizations plan data collection, build appropriate infrastructure, and accurately track outcomes
5. Offer capacity-building workshops and host ongoing office hours on program evaluation for smaller, Asian-led CBOs, ensuring they have the tools and guidance needed to meet reporting expectations without being disproportionately burdened.

CONCLUSION

City-funded programs must be evaluated in ways that capture the depth and complexity of services required to advance equitable mental health outcomes for immigrant Asian New Yorkers. Asian-serving CBOs provide essential culturally and linguistically competent support, but they can do so effectively only when evaluation systems value qualitative outcomes and the intensive nature of this work. The Asian American Federation remains committed to providing equitable, culturally competent care, alongside our Asian American Mental Health Roundtable partners, and advocating for more inclusive mental health policies. Thank you for the opportunity to testify, and we look forward to working with the Council on this issue.

ACT UP Testimony to the Committee on Substance Abuse, Mental Illness & Homelessness:

The advent of nerve growth promoters such as ibogaine completely changes the calculus of public health in the treatment of substance abuse. It will save New York money at every step.

We, the Research/Access Working Group at NY Act Up, acknowledge that New Yorkers with financial resources are already accessing ibogaine in Mexico, Costa Rica, or Brazil, being treated for a week or two, and coming home clean. While these programs can cost the patients from 5 to 12 thousand dollars, we can do it here for about $2000 per patient.

Ibogaine researchers have found that for opioid substance use disorder, fifty percent of the ibogaine patients are able to stay opioid fre for 6 months after a treatment. This is phenomenal compared to NA, peer support, suboxone and methadone. The cost of lifetime medication is cancelled. For cocaine and methamphetamine the only conventional pharmacotherapy is wellbutrin—effective for only 1 in 10. Adding naltrexone increases that 2%! Since ibogaine regenerates dopamine neurons directly, the numbers for psycho-stimulants are a bit better than 50%. A bonus is that about 50% also recover from their need to use tobacco and alcohol: a leading cause of death and a huge social and law enforcement problem.

This is a hospital procedure, requiring medical supervision during the acute phase (2 to 3 days). Patients must be screened for pre-existing conditions and any other meds before treatment. Additionally, because the treatment is swift, it frees up their bed for other treatments after a week, unlike the 90 day treatment model for other detox/rehab programs.

This is a gigantic gift to our economy and social service systems. Nonviolent drug offenders clog our courts, fill our jails, and resist efforts to modify their behavior. Addictions are a mighty driver of social problems and a public health nightmare.

People who use IV drugs also spread Hep C and HIV. They are more likely to do so if they cycle in and out of jail. The other principal vector of HIV transmission is Chemsex with crystal meth. During their lifetimes, people with HIV generally cost our healthcare system, and Medicaid programs, about 500,000 dollars per patient. If the patient's HIV diagnosis is delayed three years (perhaps because our HIV Prevention Budget was just cut), that number jumps to 1 million dollars. We believe that offering addicts this additional therapy option will meaningfully reduce transmission of HIV and total HIV healthcare costs.

In addition, particularly amongst people with psychiatric disorders, ibogaine often also resolves the underlying problems that are driving substance abuse and homelessness.

The costs of keeping nonviolent offenders in jail is astronomical. What if we could offer a diversion program in the form of an ibogaine treatment option? DOC has 3 hospitals all rehabbed and ready to go that are not being used for Rikers patients because of staffing issues. What if the Belleview facility at 462 1st Ave was

transferred to DOHMH so that both people under court supervision as well as the general public could benefit from this medical breakthrough?

That 100 beds could provide treatment for up to 5200 people a year. More than enough to address the treatment shortfall that's keeping us from closing Rikers! Let's support an Ibogaine Drug Treatment Diversion option through the establishment of a clinic with the oversight of doctors from Columbia University with a background in this type of therapy.

TESTIMONY OF VAN YU, MD

Chief Medical Officer
Center for Urban Community Services / Janian Medical Care

Before the New York City Council
Committee on Mental Health, Disabilities and Addiction
Oversight Hearing: Evaluating DOHMH's Systems for Measuring Outcomes and Equity in City-Funded Mental Health Programs

December 17, 2025

Good afternoon, Chairperson Lee and members of the Committee. My name is Dr. Van Yu, and I serve as Chief Medical Officer at the Center for Urban Community Services, also known as CUCS, and its healthcare affiliate Janian Medical Care. Thank you for the opportunity to testify today about our Intensive Mobile Treatment program and the critical need for data transparency in our city's mental health system.

Who We Serve and What IMT Does

CUCS operates eight IMT teams serving more than 200 New Yorkers who have fallen through the cracks of our mental health, housing, and criminal justice systems. IMT is a fully funded, multidisciplinary treatment model launched in 2016 to reach adults with complex needs who have frequent contact with multiple systems and are often unable to engage in traditional care.

IMT works because we prioritize relationships over everything else. By building trust over time and meeting people where they are, we create the safety net participants need to engage in treatment and start to build new lives. Our teams maintain deep knowledge of each participant to anticipate decompensation, intervene early to prevent hospitalization, coordinate care across systems, and bridge gaps so that systems designed for less complex cases can more effectively serve this population.

The most consistent characteristic of IMT participants is an inability to develop sustained, effective relationships with other systems. IMT is structured to provide the time, flexibility, creativity, and clinical expertise required to initiate and nurture effective working alliances with participants. There is no progress without such sustained alliances.

Demonstrated Clinical Success

Our outcomes speak to the effectiveness of this model. IMT teams achieve significantly better results than national averages for unhoused populations:

- Medication adherence for people with schizophrenia: 72%

- Medication-assisted treatment for opioid use disorder: 56.7% compared to the national rate of 25% for unhoused populations

- Long-acting injectable medications for psychotic disorders: 57.3% compared to just 4% nationally for unhoused populations

In November 2025 alone, Janian IMT psychiatrists conducted 133 visits with 116 CUCS IMT participants and provided 226 medication prescriptions to 61 participants. This level of consistent psychiatric engagement would be impossible in traditional treatment settings for this population.

Let me share a concrete example. Participant “R” was referred to IMT after spending over 10 years in the shelter system, and being transferred multiple times per year due to behavioral issues including assaults against staff and other residents. She is diagnosed with schizoaffective disorder and has had multiple emergency room visits and inpatient psychiatric admissions with no long-term progress.

IMT was able to work closely with her shelter, meet with her frequently, and identify patterns in her behavior. We discovered she was having absence seizures that were causing confusion, exacerbating her paranoia, and leading to violence. Once she began taking medications for both seizures and schizoaffective disorder and moved into housing, her paranoia slowly improved. Her psychiatric hospitalizations and violent incidents reduced to zero. She reconnected with her adult children, met her grandchildren, and graduated from IMT this year..

The Value of Integrated Psychiatric and Medical Care

A significant value of IMT healthcare not seen in other models in the city is what we call primary care psychiatry. Our psychiatrists and nurses provide extensive relationship building while serving as medical care coordinators and general practitioners for participants who are unable or unwilling to access traditional medical care. In addition to providing care directly for psychiatric, substance use and even physical health conditions we also link people with medical subspecialists.

Consider Ms. “P”, a 68-year-old woman who had been chronically street homeless for 15 years. She had severe leg swelling impacting her ability to walk and was unwilling to see physicians at clinics or go to the emergency room. After building rapport with the team, we supported her going to an ER to ensure she did not have a life-threatening condition. Our team nurse stayed with her for the entire visit, which lasted many hours. Although she did not have deep venous thrombosis, she had significant hypertension. She only followed up with primary care with the escort and accompaniment of IMT.

She was started on anti-hypertensive medication but was not amenable to follow up with other doctors very often. Our team psychiatrist and IMT have been able to continue her medication, and she has been comfortable, mobile, and out of the hospital since. Ms. “P” has also moved into housing and is social with friends, enjoying walking around her neighborhood.

Or take Mr. “W”, a 40-year-old man diagnosed with schizophrenia who has consistently refused to follow up with primary care since IMT engaged him in 2020. In addition to his behavioral health condition, he had a history of poorly controlled diabetes. His Hemoglobin A1c was found to be 11.7 in 2022, putting him at risk of hospitalization, ER visits, and cardiovascular, renal, infectious, and other health consequences of uncontrolled blood glucose.

Mr. “W” has only been willing to take medications prescribed by the IMT psychiatrist. Our team has managed his diabetes over the years in consultation with Janian primary care. His most recent Hemoglobin A1c was reduced significantly to 7.7 in April 2025, representing a significant reduction in his risk from diabetes.

Then there's Mr. “C”, a man in his early 50s with a long history of trauma, major depressive disorder, alcohol and crack use disorder. He was referred to the team with a history of frequent emergency service involvement related to public intoxication and harassing people on the street. He had a long history of street homelessness, has bilateral lower extremity amputations due to frostbite and neglect, and had been followed by a city Street Outreach Team.

Mr. C demonstrated aggression towards the team initially. One time, he threw hot coffee at team members. Through repeated relationship building by IMT through near daily visits, he developed a

relationship and became more willing to work with the team and accept medications. He accepted medications for mood and naltrexone for alcohol use disorder. He also started accepting his blood thinner, Eliquis, which the team helps him obtain from Harlem Hospital. His alcohol use has decreased significantly. Last year, the team helped him obtain prosthetics funded through a charitable organization. His physical health risk and ER utilization has significantly reduced.

Cost-Effectiveness: A Smart Investment

The economic case for IMT is compelling. Our program budget is approximately $9.6 million across eight teams, which comes out to about $44,400 per participant annually. Compare this to:

- Median psychiatric ER visit in NYC: $1,000 to $3,500 (not including EMS or NYPD costs)
- Two-week psychiatric inpatient hospitalization for someone experiencing homelessness: $21,000 to $25,000 (not including EMS or NYPD costs)
- Inpatient medical hospitalization for someone with serious mental illness and homelessness: $13,500 to $15,000 per admission
- Annual cost of incarceration at Rikers Island: approximately $507,000 per person

For the actual clinical services we provide, our costs are remarkably efficient. Street medicine costs $2,464 per day, which breaks down to $410.67 per patient visit when our teams see an average of six patients. This includes a street medicine provider and nurse working together. Primary care costs $1,652 per day, or $275.33 per patient visit based on six patients seen.

When you consider that a single two-week psychiatric hospitalization can cost up to $25,000, the value of IMT's preventive, relationship-based approach becomes crystal clear. We are not just providing more affordable care, we are providing better care that prevents the costly crises that have defined these individuals' lives for years.

The Data Transparency Problem

Despite IMT's proven success, we face a significant challenge: lack of access to data we need to continuously improve our work and demonstrate our full impact. For at least eight years, providers have been entering data into DOHMH systems with very limited access to information in return.

I want to acknowledge that DOHMH has taken meaningful recent steps to begin sharing data with providers. On November 24, 2025, DOHMH met with us and shared several key performance indicators showing that providers can formally request access to this data. DOHMH has also recently implemented a new reporting function that allows providers to download raw data reports. While this data is not yet analyzed, our quality assurance department is working on analyzing and reporting findings.

These are positive developments, and we appreciate this progress. However, significant gaps remain. When we formally requested access to housing retention data, housing placement data, and psychiatric hospitalization data on December 15, 2025, we were told the request is pending an update from the Office of Treatment Rehabilitation and Care Coordination.

From my perspective as Chief Medical Officer, the data we lack is precisely what we need to demonstrate IMT's full impact on the healthcare system. We need utilization data from other systems, particularly hospitals and forensic settings. If DOHMH could collect and analyze Medicaid utilization data of IMT participants, it would provide a helpful picture of how healthcare utilization, including high-cost hospital care, changes over time.

More specifically, we lack:

- Comparative data for participants before IMT and with IMT
- Medication data to compare with outcomes
- Information about previous treatment modalities that have not worked, such as state hospital, ACT, FACT, or SOS
- Duration of time a participant has an active housing packet and is not housed
- Level of service data alongside key performance indicator data

How Data Gaps Hinder Our Work

These data gaps have real consequences for our ability to serve participants effectively:

Without live comparison between level of service and outcomes both in the short and long term, we cannot confidently develop guidelines to increase or step down services using an evidence-based scale.

Without data showing trends across various populations and locations, we cannot increase use of effective interventions for specific groups or increase effective advocacy and partnerships in the community with specific hospital or other service systems identified as having a pattern of negative outcomes.

Without longitudinal data about needs, we cannot identify patterns about how to adjust staff training and increase use of specific, effective interventions.

We have observed potential disparities in outcomes between different diagnoses, based on the number of years someone has been incarcerated, and based on housing status. But without systematic data collection and analysis, we cannot fully understand or address these disparities.

What We Need: Specific Recommendations

To truly evaluate outcomes and equity in city-funded mental health programs, we recommend that DOHMH:

First, provide data on the number of days incarcerated, number of days hospitalized, number of ER visits, and number of arrests for a period of time before IMT and after being connected to IMT. This comparative data is essential to demonstrating the full value of the program.

Second, allow IMT providers to access data entered into MAVEN in a way that allows us to see relationships between services provided and outcomes, controlling for demographics, diagnosis, and setting.

Third, create a real-time data dashboard that tracks number of days hospitalized, incarcerated, or missing in a given time frame; number of ER visits and arrests; number of contacts with IMT; and relationships between those data points and diagnosis, length of time with IMT, race, gender, age, medication type, and housing type.

Beyond Data: Critical Operational Challenges

While data transparency is critical, I also want to briefly highlight two other operational challenges facing IMT programs:

Staffing is the primary challenge. IMT teams are made up of staff who deal with crisis, secondary trauma, and deeply complex human stories every single day. To retain staff who have the skill, creativity, and heart for this work, we need compensation that reflects the intensity and specialization of the role. IMT work requires intensive, on-the-job training so staff can effectively support participants with complex mental health diagnoses, significant medical needs, and varying levels of cognitive and intellectual functioning. This level of training is not sustainable without long-term staff retention.

Second, IMT needs direct access to Safe Haven beds and prioritization for supportive housing. Participants' complex medical and psychiatric needs cannot be adequately addressed while they are living on the street or in shelters. These environments contribute to disengagement from care, increased emergency room utilization, and heightened risk of violence.

Conclusion

IMT represents a proven, cost-effective approach to serving New Yorkers who have been failed by traditional systems. We are preventing hospitalizations, reducing incarcerations, improving health outcomes, and fundamentally changing lives. But to scale what works, to address disparities, and to continuously improve our practice, we need transparent, timely access to comprehensive data.

We appreciate DOHMH's recent steps toward greater data sharing and look forward to continued progress. With the Council's oversight and DOHMH's commitment to transparency, we can ensure that every city-funded mental health program has the data needed to deliver equitable, effective care.

Thank you for your time and attention to these critical issues. I am happy to answer any questions.

Oral Testimony

Thank you, Chair Linda Lee, and members of the Committee on Mental Health, Disabilities, and Addiction, for holding this hearing and providing us with the opportunity to testify. I am Yuna Youn at the NY state MHOTRS Mental Health Clinic at KCS, where we provide clinical and psychiatric services and a host of other programming incorporating community psychoeducation, family therapy, art therapy, and more. We are here today testifying as part of AAF's Asian American Mental Health Roundtable.

I'd like to start off with a brief vignette. When we interview clinicians, as expected they bring up the market value for their position if they were to work in institutional settings or private practice. However when we can only provide a non profit rate, our current staff have all mentioned that they would like to work at KCS because they want to serve Korean and immigrant clients, knowing the barriers they face and the lack of access to trauma informed, culturally responsive support in their own language. This is rare. Our providers are the bedrock of our clinic, and we want to make sure that their work is sustainable and that they are financially secure and not have to feel they are sacrificing their own wellbeing and financial safety over their clients.

Our experience with delivering services and matching them to grant reporting requirements directly matches the points that AAF raised. Our providers truly care and provide meaningful care grounded in relationships that they build with clients, something that cannot be expressed in numbers. We see the progress in the full spectrum of needs that are met-children who don't readily communicate, finally opening up through art therapy and eventually engaging in family therapy, individuals and couples becoming better aware and able to care for themselves and others. Those with severe mental illness, gambling and substance use issues mandated to counseling, suicidal clients and new clients discharged from psychiatric facilities, all of them have come through our doors and left better equipped to handle their challenges and connected to a wide array of other social services and community supports.

This work takes much time, tremendous dedication, and teamwork. We were notified yesterday that our OMH was recertified, a process occurring every three years but due to COVID happened in 6 years. The intensive documentation process for OMH clinics in addition to all the reporting for city discretionary grants, requires buy-in from all our staff, including fee for service staff who work full time jobs. KCS remains committed to providing equitable, culturally competent care.These are but a few examples of why we need evaluation systems that value qualitative outcomes and the intensive nature of this work.

Thank you for the opportunity to testify today.

NYC Council Committee on Mental Health, Disabilities, and Addiction

DOHMH Oversight Hearing: DOHMH's Systems for Measuring Outcomes and Equity in City-Funded MH Programs (12/17/25)

The following testimony is submitted by:

Irene Walcott, LCSW
Vice President of Behavioral Health
Lantern Community Services
December 19, 2025

Thank you, Chairperson Lee and Council Members Mealy, Louis, Williams, Bottcher, Caban, and Hanif, for convening the Oversight Hearing on DOHMH's Systems for Measuring Outcomes and Equity in City-Funded Mental Health Programs on 12/17/25. I attended the hearing last week and was very grateful to hear from DOHMH's Executive Deputy Commissioner and Associate Commissioners, and from my colleagues at agencies impacted by this important topic. I am writing now with my own testimony speaking to this matter, from my experience over almost 20 years of providing case management, health education, and clinical services in street outreach, emergency shelter and supportive housing settings. For the past seven years, I have worked at Lantern Community Services (Lantern), one of many NYC-based supportive housing providers supported by DOHMH, currently in the role of Vice President of Behavioral Health.

Lantern operates nine supportive housing programs for single adults, young adults aging out of foster care, families, and children with heads of households with special needs in Manhattan, Brooklyn, and the Bronx who receive DOHMH funding:

- In Brooklyn: Euclid-Glenmore Hall, Hunterfly Trace Hall
- In Manhattan: Huntersmoon Hall, Prospero Hall, Rustin House
- In the Bronx: Cedars/Fox Hall, Jasper Hall, Lindenguild Hall, Vicinitas Hall

We are exceedingly grateful for the funding DOHMH continuously provides, allowing us to provide safe spaces and compassionate services to our participants. We are also deeply grateful to have been the recipient over the past several years of awards from philanthropic organizations including the CDC Foundation, Mother Cabrini Health Foundation, Brooklyn Community Foundation, Levitt Foundation, and most recently Corporation for Supportive Housing (CSH), which has allowed us to implement a variety of programs focused on harm reduction, tenant peer leadership and training, and health equity and justice. These programs have allowed us to enhance our services and supports in ways that are accessible, equitable, collaborative, and most importantly informed and driven by the leadership, commitment, wisdom, skills, and lived experience of our tenants. This work has included the following initiatives:

- A robust peer-driven vaccine equity program to increase awareness of, access to, and uptake of COVID-19 and other vaccinations and to address hesitancy around vaccination and other forms of healthcare among historically marginalized

and harmed communities. Within one year increased vaccinations rates from under 40% to over 95% among supportive housing tenancy of over 900 individuals.
- Development of a Tenant Advisory Board for Harm Reduction, inviting tenant leadership within our Harm Reduction Committee, to inform policy and practice
- Training our tenants to become certified Community Health Workers (CHW) and Certified Recovery Peer Advocates (CRPA)
- Broad provision of Naloxone, Fentanyl and Xylazine Test Strips and other life-saving and life-enhancing kits and supplies (for safer use, as well as safer dating, managing symptoms, hygiene, first aid, and recreation)
- Compensating tenants for their provision of health awareness and education programming to their neighbors within our buildings (e.g. tablings, groups, etc.)
- Training our tenants to provide their peers with HIV Self-Testing Kits and safer sex supplies, to increase awareness of HIV status and connection to care
- Development of person-centered, harm reductive substance use and suicide and homicide risk assessments, designed to collect and utilize tenant experiences to guide actionable services and supports

Lantern was just awarded funding from CSH for 2026-2027 to pilot programming to better support tenants in supportive housing with high acuity needs (related to serious mental illness, high risk substance use, chronic physical health conditions, and behavior that creates disruptions for the community). The model we will pilot is an innovative Intensive Case Management Program model, adapted for more realistic fit with supportive housing staffing and funding structures. We have specifically designed the program in such a way that the majority of the work our staff will do as part of this Adapted-ICM model is funded through contracts such as those we currently receive from DOHMH, while making very strategic and intentional use of agency leadership who have clinical knowledge and training in designing the model and providing clinical oversight and supervision.

We were so appreciative of Public Advocate Jumaane Williams' statements at the start of the Oversight Hearing last week in reference to the challenges of social work professionalization within NYC Mental Health programs and have experienced that firsthand as an agency. Among the many mental health programs DOHMH implements and supports, Permanent Supportive Housing is historically one in which staff are less highly equipped with clinical training and knowledge. The PSH model is based solidly in engagement, rather than specific clinical interventions, which is part of what makes it financially feasible on the large scale. With an increasingly high acuity population in supportive housing, however, it is clear that on-site clinical support and oversight is critical. In response to these challenges, Lantern has worked diligently over the past several years to expand our clinical capacity in the following ways:

- Seeing that it was difficult to recruit staff with clinical backgrounds, Lantern has:
    - Invested in current staff through programs like DOHMH's MSW Scholarship Program, both to build clinical capacity and to lift up our staff with deep knowledge and context of supportive housing and the populations we serve

    - Made very thoughtful pay scale adjustments in order to draw staff to the agency who are skilled and experienced in working with individuals and families with higher acuity behavioral health needs
- Investment in the RELISH (Readying Emerging Leaders in Supportive Housing) program, consistently supporting Lantern staff to participate in order to build their skills and networking as leaders in the field of SH
- Increasing senior leadership (specifically at the VP-level) to ensure there is a solid base of leadership staff who have both a high level of skill and experience in clinical and evaluative work, while also being solidly grounded in the day to day work our supportive services staff are engaged in
- Most recently we have developed a model for providing Clinical Supervision for staff with their MSWs and LMSWs to support license attainment/progression that ensures these staff are actively engaged in work with individuals that focuses on diagnosis, psychotherapy, and treatment planning

We could not have found ways to more deeply live out the values of a true Housing First model if not for the funding, technical assistance, and partnership provided by our philanthropic partners to implement these innovative programs. As we all know, the Housing First / Permanent Supportive Housing model is in significant jeopardy and now more than ever it is critical to implement programs that can yield robust qualitative and quantitative data on the effectiveness of PSH and other evidence-based models, not only as they have been implemented to date, but with innovations and enhancements that will increase their efficacy, accessibility, replicability, scalability, and sustainability.

We are asking DOHMH to consider strategies to enhance supportive housing organizations' capacity to implement **innovative programs and practices** and **enhance clinical capacity** by partnering with agencies like Lantern in exploring ways to:

- Increase and enhance staff capacity, specifically for staff who can support robust QA/QI and clinical work at the site-level
- Provide training and technical assistance, to inform more robust data-driven and clinical understanding and practice among all PSH staff/roles
- Invest in shared data systems that will allow greater data transparency, sharing, and learning across agencies and city/state-wide
- Create "containers" for program innovation that invite services and supports that are clinically and evidence-informed, contextualized, deeply support self-determination and self-efficacy of our populations, and which are creative and inherently optimistic in nature

We are confident that through creativity, innovation, and a solid grounding in data, evaluation, and the value of lived experience of our tenant populations, we can work collaboratively within the NYC Supportive Housing industry to develop adaptations and enhancements to make Housing First / Permanent Supportive Housing an even more effective and sustainable model at a time when it is most critical to ensure that our staff are well supported and well invested in, and that the individuals and families we serve are given every opportunity for safety, health, stability, and fulfillment. Thank you for

your time and attention reviewing this testimony, and for eliciting the experiences, ideas, and hopes of agencies like Lantern Community Services.

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I represent: DOHMH

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Address: [redacted], NYC 10025

I represent: Act UP

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I represent: Asian Medical Care / Center for Urban Community Services

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I represent: Northside Center for Child Development

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Address: [redacted]

I represent: Astar American federation

Address: 120 wall street, 9th floor

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Name: VAN YU

Address: _____

I represent: CENTER FOR URBAN COMMUNITY SERVICES

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