CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

MENTAL HEALTH, DISABILITIES
AND ADDICTION

Jointly with the

COMMITTEE ON HOSPITALS

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Tuesday, January 28, 2024
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HELD AT: COMMITTEE ROOM, CITY HALL

B E F O R E: Linda Lee, Chairperson
Mercedes Narcisse, Chairperson

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Gia Mitcham
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SERGEANT AT ARMS: Good afternoon and welcome to the New York City Council hearing of the Committees on Mental Health, Disabilities, and Addiction, jointly with Hospitals. At this time, can everybody please silence your cell phones. If you wish to testify, please go to the back of the room to file a testimony slip.

At this time and going forward, no one is to approach the dais. I repeat, no one is to approach the dais. Chairs, we are ready to begin.

CHAIRPERSON LEE: Good afternoon, everyone. My name's Linda Lee, Chair of Mental Health, Disabilities, and Addictions Committee.

I'll get right to it.

I'm excited to hear the data information that we've been asking for in terms of the funding that our wonderful Attorney General has fought so hard for to get us the opioid settlement funds. And so today really is just hopefully diving more into details about how the money is being spent, which programs it's going to, you know, any methodology you guys are using to figure out how it gets to the community groups and which zip codes it's going to.

So, very, very excited to hear from you all on all of those things. And just to make sure that we are addressing that because obviously I think knowing that information and having that data is going to help us figure out how to move forward more effectively.

So, I'm looking forward to today's hearing. So, at this time I want to recognize-- obviously I'm joined by Co-Chairs Mercedes Narcisse, and also we're here with Lynn Schulman, Councilmember Schulman, who's Chair of Health, and then also Councilmember Cabán.

And on Zoom we have Christy Marmorato as well as Councilmember Brooks Powers, Councilmember Moya, and Councilmember Palladino. So, we have all of them joining us via Zoom. So, thank you all for being here.

And, of course, we want to thank our committee staff for their hard work in preparing today's hearing, as well as advocates, providers, and individuals with lived experience who will be sharing their perspectives.

At this time, I'd like to turn the floor over to my colleague and Co-Chair for today's hearing, Chair Narcisse, of the Committee on Hospitals.

CHAIRPERSON NARCISSE: Good afternoon, everyone. I'm Councilmember Mercedes Narcisse, Chair for Committee on Hospitals. I'd like to start by extending my sincere thanks to Chair Lee. We know her experience, lived life experience, and she's the Committee on Mental Health, Disabilities, and Addiction. For convening this hearing, I want to say thank you to you.

I know that Chair Lee has been incredibly active in championing the accessibility and availability of treatments and support services for individuals who are affected by the opioid crisis, and I'm honored to be working alongside you to improve our city's response to this epidemic.

The opioid crisis, which has been raging for over a decade now. In my time it was crack, but this has affected thousands of New Yorkers and their loved ones. And from being a registered nurse, I can tell you firsthand, it is a disease. Unfortunately, we're not taking ones that are addictive to drugs as a disease, but it is a disease.

As a result of two lawsuits brought against the manufacturers and distributors of prescription opioids, the city had received over $154 million, and we expect to have a total of more than $500 million by 2040.

In addition to those funds, we may see an extended figure come in as a result of last week's settlement agreement that our Attorney General announced. It is imperative that the settlement money that the city receives is allocated toward appropriate harm reduction and treatment programs. Once in my life, I had experience working for a re-entry program, and there was a lot of addiction that we had to deal with. So I'm so happy for that settlement.

While the number of deaths attributed to overdose has decreased in recent years, we still have a very, very long way to go. Drug overdose remains a leading cause of premature death across the city.

With the presence of fentanyl and xylazine further exacerbated the likelihood of overdose fatalities. Last year, the Department of Health and Mental Hygiene announced that the city lost 3,046 people to opioid overdoses in 2023. The rates of

overdose death continue to be highest among Black and Latino New Yorkers, and residents of the neighborhood that have been historically under-invested.

We must increase the supports that we provide to New Yorkers who are at their highest risk, and to improve the outreach we conduct to make sure that everyone knows what treatment-- I mean, options are available.

Our city is home to advocates and organization who do incredible work (I can see some in the room right now) to support each other in their communities, and we will continue to collaborate with them to achieve our collective goal of reducing opioid addiction and related deaths.

Today, I'm grateful to have the opportunity to discuss the various initiatives that the city has implemented to combat this crisis.

I look forward to hearing from all members of administration so that we can identify the most productive ways to capitalize on the disbursement of the opioid settlement funds. We know sometimes when there is a disbursement, and we don't know where it goes, but we just want to know. And particularly, I'm eager to speak with the New York City Health and

Hospital Corporation, and to learn about how their substance use clinics and overdose response programs have been operating.

These funds are a crucial weapon to combat the opioid crisis, and we will continue to ensure that patients suffering from addiction and substance use can access the support that they need.

It is imperative that we utilize all available data and funding to maximize the positive impact that harm reduction programs have on the communities they serve.

Our hearts goes out to everyone who has been affected by this epidemic in New York City and across the country, and we are committed to continuing the work to heal those who are suffering.

I can tell you that listening to folks that I know about the family members that are affected, not even now, even back then, people that's great people, beautiful people, when they're under the drug controls, they're a different person, they become a beast. That's not the person. It's an addiction, and it's a problem.

I have work in the emergency room where people will take the papers, throw in my face, throw other

things on my face when I'm not giving them what they come for, because we have a process, and you give them a few minutes when they get their medication or back then methadone, and you would see it's a beautiful person.

So, that's what I have to say to that, my own life experience.

Before we begin, I'd like to thank committee staff, legislative council, Ria Ogasawara, and policy analyst, Mahnoor Butt. For now, I just heard that she might be leaving me very soon. I had a great experience with you, Mahnoor. Thank you for your hard work in preparing for this hearing.

I'd also like to thank my staff, Saeed Joseph, Frank Shea, and Stephanie Lynn, for their work as they strive to serve the city council and our constituents, and I cannot forget my director of constituent services, Irina Klevner.

With that, I now turn back to my colleague, Chair Lee. Thank you.

CHAIRPERSON LEE: Thank you. Just want to recognize you've been joined by Councilmember Bottcher, and without further ado, I will turn it

over to Councilmember Lynn Schulman, chair of the Committee on Health, to offer her remarks.

Thank you, Chairs Lee and Narcisse, for holding today's critical hearing on the Opioid Settlement Fund. I am Lynn Schulman, chair of the Committee on Health.

My thanks to the chairs for including me here today in my capacity as Health Committee Chair to discuss how opioid settlement funds are being used by the city to address and reduce the harms caused by the opioid crisis. I am particularly interested in how the Office of the Chief Medical Examiner, or OCME, is utilizing these funds, and I look forward to learning more from OCME about this today.

In September 2024, the mayor announced the administration's plans for applying $50 million in funding annually by fiscal year 2027 to combat the opioid addiction crisis New Yorkers continue to face.

These plans include an annual $4 million investment in OCME. An initial investment stemming from the Opioid Settlement Fund supports the Drug Intelligence and Intervention Group, which offers tailored support for the families of drug overdose decedents by connecting them to critical mental

health and social support services in the crucial window following an overdose death.

The Drug Intelligence and Intervention Group program, which was launched within OCME in late 2022, has served 1,300 individuals as of September 2024. This program is comprised of trained social workers and public health professionals and has offered support to surviving family members and close contacts as they cope with pressing needs in the wake of the overdose deaths of loved ones.

OCME reports that program participants have accepted a wide range of services, including grief and bereavement support, mental health and substance use counseling, healthcare and housing support.

OSF funds will also support the hiring of additional scientists and support staff at OCME and will provide new equipment and physical upgrades to the Forensic Toxicology Laboratory and allow for information technology improvements.

OCME's stated goal with this funding is to reduce turnaround times by half by September 2025 to expedite answers for grieving families and data to partners in the public health system. These investments build on the city's work to reduce opioid

deaths by 25% as part of HealthyNYC, the city's plan to extend the average lifespan of all New Yorkers to 83 years of age by 2030.

I am deeply proud to have sponsored the legislation that codified HealthyNYC and I remain committed to ensuring that DOHMH and OCME have the resources and tools they need to reach the HealthyNYC goals and address the harms of the opioid addiction crisis. Through collaboration and transparency, we can ensure that these funds are strategically allocated towards programs and services that deliver much needed relief for our communities.

In closing, I want to thank my staff and the committee staff for their work on this hearing and I want to thank the representatives and the administration for being here today and I also want to give a shout out to Mahnoor Butt, who has been selected to be on the speakers, on the city council's rather charter revision commission as staff and I really appreciate all the work that she's done for me as committee chair of health.

I will now pass the mic back to Chair Lee.

CHAIRPERSON LEE: Awesome, I'd also love to offer my congratulations to Mahnoor.

Okay, so I am going to turn now over to our Legislative Counsel to administer the oath to witness from the administration.

Oh yeah, sorry.

COMMITTEE COUNSEL: Now in accordance with the rules of the council, I will administer the affirmation to the witnesses from the mayoral administration. Please raise your right hand.

Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honestly to Councilmember questions?

PANEL: I do.

COMMITTEE COUNSEL: Thank you. Prior to delivering your testimony, please state your name and title for the record. You may begin.

DR. LINN-WALTON: Okay, good afternoon Chair Lee, Chair Narcisse and members of the committee. I'm Dr. Rebecca Linn-Walton, assistant commissioner for the Bureau of Alcohol and Drug Use at the New York City Department of Health and Mental Hygiene, the Health Department.

On behalf of acting commissioner, Dr. Michelle Morse, I thank you for the opportunity to testify

today. I'm pleased to be here and discuss how the Health Department is utilizing the funds obtained through the litigation efforts and settlements secured from manufacturers and distributors of prescription opioids by both the New York City Law Department and the Office of the New York Attorney.

New York City is still facing a devastating overdose crisis. Addressing this crisis is at the forefront of the Health Department's strategic priorities and planning.

A central goal in HealthyNYC, the city's roadmap for increasing average life expectancy, is to reduce overdose deaths by 25% by 2030. We work closely with our partners at the Mayor's Office, the Office of Management and Budget, OMB, Health + Hospitals, and the Office of the Chief Medical Examiner, New York State, and community-based organization to make progress toward this goal. I'm proud to be part of this work.

First, I want to address some common questions regarding the allocation of opioid settlement funding across New York State. We have included, as Appendix A, a pie chart to show the distribution of funds. As you can see, New York City was allotted 20% of the

opioid settlement funds that were secured as a result of New York City and the New York State Attorney General's lawsuits. The Mayor's Office and OMB oversee these funds and determine how they are spent across city agencies as part of the city's budgeting process.

Appendix B outlines the flow of opioid settlement funds to the city and the breakout of funding by agencies represented here today. The city developed a phased approach to deploying the opioid settlement funds to address this crisis.

With the New York City allocation, we are spending, improving, and modernizing the entire opioid settlement fund and the entire spectrum of substance use care and support from harm reduction to treatment and recovery so that we can meet people where they are and support their health goals. The Health Department's role in addressing this crisis and supporting New Yorkers with substance use disorders is part of this continuum.

At the Health Department, we start with data. The data gives us insights on the prevalence of substance use and its associated health impacts.

This creates a foundation for the city to make informed programmatic decisions and investments.

In October, we published the annual summary in overdose deaths in 2023. The number of overdose deaths was 3,046, a 1% decrease from 2022, marking the first decline since 2018. Additionally, according to provisional data, there were 616 overdose deaths in the first quarter of 2024, the lowest quarter on record since 2020. This is a welcome stabilization after years of continual increase.

Every life saved is a triumph worth acknowledging. This information also tells us there's still a great deal of work ahead of us. While we are on pace with the rest of the country in decreasing deaths, we continue to lose a New Yorker to fatal overdose every four hours.

Inequities in certain neighborhoods and populations remain stubbornly high, such as older black men, and we are seeing increases in overdose among Latino New Yorkers and women.

The Health Department is committed to reducing these inequities and supporting healing in the communities most harmed by this crisis.

The Health Department also implements a significant array of programs to reduce substance use and its negative health consequences. This includes the delivery of substance use prevention and harm reduction services. We contract with 14 syringe service providers and six outreach and syringe litter teams. These are community-based organizations that provide access to sterile syringes as well as collect and safely dispose of used syringes found in the communities they serve.

They also provide a range of health services, including naloxone distribution, overdose education, HIV and hepatitis C testing and counseling, drug treatment counseling, support groups, drop-in counseling, opioid addiction treatment with buprenorphine, and referrals to physical and mental health care and other drug treatment programs. The Health Department also provides community naloxone and test strip distribution, drug checking services, and education and training services across the city. Given the scale of the crisis, we have implemented innovative solutions such as the public health vending machines which are located in four locations and provide 24-7 convenient and anonymous access to

public health and wellness supplies. The Relay Program, a non-fatal overdose response initiative: Relay supports people who have experienced a non-fatal overdose by sending a peer wellness advocate to participating emergency departments to provide support, overdose risk, education, and naloxone. This is all in addition to supporting buprenorphine access, treatment and recovery, and peer workforce development programs.

As you can see, the Health Department provides critical insight and programming to the city's data-driven, evidence-based approach. The opioid settlement funds enable the city to enhance this work and better meet the demands of this crisis.

I want to now turn to the Health Department programming supported by the opioid settlement funds.

Beginning in fiscal year 2023, the Health Department utilized $8.6 million in opioid settlement funding to expand wraparound services and hours at existing syringe service programs to strengthen care connections and increase hours and support community naloxone distribution. As part of the city's phased release of opioid settlement funding, the Health Department's total allocation will scale up to $23.7

million annually, beginning fiscal year 2026. This enables us to address gaps in the continuum of support and care and reduce overdose deaths.

Starting in fiscal year 2026, the Health Department will use $4.1 million to expand wraparound services at all 14 syringe service providers. $1 million will be used to expand the relay program to two additional emergency departments, which will bring the total number to 17 emergency rooms citywide. This $3 million will improve and expand substance use service provision on Staten Island through partnerships with eight community-based organization across prevention, harm reduction treatment and recovery services.

Additionally, $4 million will be allocated to expand methadone and buprenorphine treatment programs and $3 million to expand recovery supports. The vast majority of funds will be directed to community-based organizations selected through regulated procurement process.

One of the RFPs for this new allocation is being released this week. The other procurement documents are being prepared and will be released shortly.

The Health Department maintains its commitment to providing place-based initiatives in communities most deeply affected by the opioid crisis. Our programs and initiatives span the full continuum of care and support.

I'm grateful to be doing this work alongside my city partners in order to prevent more avoidable death and improve lives of New Yorkers. The department is also deeply grateful to the Attorney General's Office and Governor Hochul for their work alongside the cities to hold bad actors accountable and secure these funds to invest back into the health of our communities. I've spent my career working directly in the field building and supporting programs that meet people in their moments of greatest crisis.

These are our neighbors, our family and even some of us in this room. Everyone deserves compassion and quality care in their darkest moments.

The Health Department appreciates the council's continued partnership in promoting the health and well-being of all New Yorkers. I look forward to answering your questions. My colleague Dr. Dan

Schatz will now give testimony on behalf of Health + Hospitals.

DR. SCHATZKER 4: Thank you and good afternoon Chairperson Lee, Chairperson Narcisse and members of the Committees on Mental Health, Disabilities and Addictions in Hospitals.

My name is Daniel Schatz and I am a primary care physician and the Medical Director of Addiction Services at New York City Health + Hospitals Office of Behavioral Health. I'm joined by my colleague Jason Hansman, Senior Advisor of Behavioral Health Communications and Policy to assist with answering any questions you may have.

Each year, over 76,000 New Yorkers depend on New York City Health + Hospitals for behavioral health services, making us the city's largest safety net provider for mental health and substance use treatment.

Our dedicated behavioral health team includes nearly 5,000 people at 11 hospitals and over 30 community health care centers. We provide approximately 60% of all behavioral health services in New York City. New York City Health + Hospitals serves as the frontline response for individuals

requiring emergency, inpatient and outpatient behavioral health care.

Moreover, our mobile and community-based services meet people where they are, breaking down barriers to care for populations who may otherwise have difficulty accessing critical services due to transportation, time, language, housing, instability, justice involvement or disability. With a wide range of high-quality, affordable behavioral health services and programs for children, adolescents, adults and seniors, we serve everyone along the behavioral health spectrum. Still, we are energized to do more to tackle the behavioral health crisis and opioid crisis we face as a city and ensure that New Yorkers who need the most support can easily access seamless, high-quality care.

New York City Health + Hospitals has always been at the forefront of delivering innovative addiction services to serve the needs of some of New York City's most vulnerable communities. To do so, we emphasize system-wide access, a culturally responsive approach to wellness, comprehensive addiction care for acute, chronic and complex needs, demonstrated outcomes and financially viable services. In

addition, training and education of both substance use disorder and non-substance use disorder staff is essential to developing the next generation of addiction champions and substantively addressing substance use-related stigma.

This ensures that patients with substance use disorder, SUD, can receive services through many points of access to our system. Whether a patient presents directly to our outpatient addiction service clinics or through our acute care facilities, emergency departments or inpatient units, we can provide meaningful, patient-centered and evidence-based interventions and care.

Thanks to New York City and New York State Attorney General James' lawsuit against the drug companies that knowingly hook patients on powerful opioids, we are helping communities heal from this crisis.

The opioid settlement funding has bolstered up our efforts to serve New Yorkers with substance use disorder, and we thank Attorney General James for her staunch determination to fight for victims of this crisis and their families.

Approximately $2.2 million has supported our mobile harm reduction teams, known as our Street Health Outreach and Wellness, or SHOW Vans, which offers a new model of care that includes testing and vaccinations, wound care and provision of basic material necessities and harm reduction services to New Yorkers who are unsheltered. Our SHOW Vans are equipped with harm reduction services, including the provision of overdose prevention supplies such as naloxone, fentanyl test strips and xylosine test strips, as well as staff who specialize in treatment of substance use disorder.

Behavioral health staff, including social workers, addiction counselors and peers, canvas the streets and high-need areas of the city providing direct concrete needs, brief counseling and referral to treatment, and help street homeless patients to access shelter, housing and benefits. Importantly, these staff engage patients where they are, earn their trust by showing empathy and respect, while helping to connect the individual to ongoing treatment when the patient is ready.

In 2024, the SHOW Vans had nearly 13,000 encounters for services. There are currently five

operational vans that are part of New York City Health + Hospitals, Bellevue, Lincoln, Woodhall and Elmhurst.

An additional $10 million of the opioid settlement funding supports the expansion of our emergency department leads, or ED leads, to increase coverage. These teams consist of licensed clinicians and peer counselors who identify patients at risk for substance use disorder, offering screening, brief intervention, referral to treatment and peer counseling services.

Patients are also offered harm reduction resources, including overdose education prevention, naloxone kits, fentanyl and xylosine test strips. In 2024, there were 24,317 ED leads encounters. Of these, 19% resulted in outpatient referrals and 8% included naloxone kit distribution.

While these numbers reflect our reach, our goal is to further increase referrals to treatment by improving follow-up care and patient engagement. We have ED leads teams at all 11 of our acute care facilities.

New York City Health + Hospitals Office of Behavioral Health is developing a novel system-wide

substance use curriculum for our behavioral health workforce called the Addiction Service Workforce Training Program. The training is supported by $2.4 million in opioid settlement funds. Upon full implementation, the program aims to reach at least 3,000 New York City Health and Hospital peers, social workers, nursing and PRIDE staff in order to, one, achieve the systemic culture change in the treatment of individuals living with addiction, and two, facilitate appropriate addiction medical treatment and care management.

The training initiatives will prepare our workforce to address substance use disorder by focusing on stigma and harm reduction, effective communication and referral strategies, and building expertise in treatment modalities.

The program also includes supporting addiction fellowships at New York City Health and Hospital facilities, and an interactive training using live actors as simulated patients with opioid use disorder to provide emergency medicine physicians an opportunity to advance their treatment of opioid use disorder in the Health + Hospital's 11 emergency departments.

Planning took place in the fiscal year of 2023, and implementation began in the fiscal year of 2024, and execution in fiscal year 25 remains underway.

With the support of $3 million of the opioid settlement funding, we launched the Addiction Response Team, a new model that will provide expanded addiction coverage to three hospitals, New York City Health + Hospitals, Harlem, Jacoby, and Queens.

This model will provide rapid delivery of life-saving medications for opioid use disorder directly in the emergency departments and inpatient units, as well as an immediate access to ongoing outpatient addiction services. Opioid settlement funding is also supporting the ongoing operations of a new health and substance use disorder clinic, part of the RISE Center, Recovery Integrated Services and Empowerment, for pregnant and postpartum women and their families, with an annual investment of $3.6 million. This clinic will offer pregnant and parenting individuals living with substance use disorder a safe and supportive place to access prenatal and postnatal care, addiction medicine, and behavioral healthcare.

Lastly, $1.2 million of the opioid settlement funding will allow us to add addiction counselors to support addiction care and birthing units across all 11 public hospital systems. This critical work will help expecting families at a time of high risk and promote the administration's goal to decrease maternal mortality. New York City Health and Hospital is deeply committed to advancing a culture and clinical shift in understanding and treating patients living with substance use disorder.

With tens of thousands of patients presenting to our medical emergency departments annually, we have an opportunity to make a positive and lasting impact during each and every one of those encounters, whether it is making our patients feel seen, treating them with dignity, reducing risk, or starting life-saving treatment, we are dedicated to addressing this crisis in a patient-centered way.

I thank your committees for your attention to this important topic, and we are happy to answer any questions you may have.

I would now like to pass it over to Robert Van Pelt, Chief of Staff with the New York City Office of the Chief Medical Examiner.

MR. VAN PELT: Thank you very much. Good afternoon, Chair Lee, Chair Narcisse, and Chair Schulman, and members of the Committee on Mental Health, Disabilities and Addiction, and Committee on Hospital. On behalf of Dr. Jason Graham, I'd like to thank you for inviting us to testify today.

Joining me today is Hannah Johnson, Program Manager of the Drug Intervention and Information Group, or DIG. We have Dr. Gail Cooper, Director of Forensic Toxicology, sitting behind me, and also Arif Khan, Assistant Commissioner of Finance.

OCME's mission is to protect public health and to serve impartial justice through forensic science and medicine. The results of our work inform legal proceedings, shape public health policy, and help families settle their affairs.

As Dr. Graham has stated, outside of the COVID-19 pandemic, the surge in unintentional drug overdose deaths represents one of the most pressing public health crises of our time. OCME has been at the forefront in tackling this crisis, as it has evolved over our city.

OCME has allocated opioid sentiment funds in two primary areas. First, an initial investment of

approximately $800,000 to support the OCME Drug Intelligence and Intervention Group, which offers tailored support to families and survivors by connecting them to critical preventative support services in the crucial window following an overdose death. And two, an investment to hire additional scientists, medical personnel, and support staff, and purchase equipment, technology, and resources to reduce the time to certify opioid deaths, which will expedite answers for grieving families and data to partners in the public health system, bringing total funding up to $4 million.

I'll review both of these investments with you and the progress we've already made.

First, the DIG. Data compiled from our years of work on this crisis have shown us that for every overdose death, there are loved ones left behind and affected by the loss, many of whom remain vulnerable to a range of unaddressed needs themselves.

Due to the intimate and sensitive nature of our mission, OCME often has unique and trusted access to these survivors, placing us in a unique position to assist, yet this initiative allows us to move beyond the traditional role of medical examiners and to

pioneer innovative solutions to meet these unmet needs. The DIG was established to address the needs of this underserved population and to combat the fentanyl-driven opioid crisis through a new and novel targeted approach.

Through this initiative, when someone dies of an overdose, OCME investigation and response now includes skilled social workers and public health professionals who engage with surviving family members and close contacts to provide a wide range of potentially life-saving services and referrals.

These interventions include grief counseling, substance use services, housing assistance, healthcare, and more. The settlement funds were invested to hire 11 of these professionals and the DIG has shown impressive results. Since the DIG's formation in September of 2022 until December 1, 2024, the team has spoken with more than 2,536 individuals who have lost a loved one.

Of these individuals, 75% or nearly 1,900 individuals have received help from DIG's family support team or referrals to programs for support.

Now to our second area of investment, an approximate $3.15 million bringing the total funding

up to $4 million used to reduce the time to certify opioid deaths. Our forensic toxicology lab is a national leader in detecting the ever-expanding universe of substances associated with the national opioid epidemic.

Through the diligent work of our scientists, the lab conducts tests for over 50 illicit and prescribed opioids, their metabolites, and potentially hundreds of other drugs and chemical toxins. This investment has enabled us to hire additional forensic toxicology lab and pathology staff to process toxicology tests and certify opioid-related results. It has also supported the purchase of new equipment, supplies, technology, and upgrades as well as contract-based assistance.

This initiative is already showing success. We are quite proud of it. The turnaround time for toxicology has improved from a median time of 77 days reported in the 2024 MMR to just 40 days now. That's a 48% decrease.

Similarly, the overall final autopsy report turnaround time has improved from 118 days in fiscal 2024 to just 84 days presently, a 29% decrease.

Having only received these funds a few months ago, these improvements indicate that we are moving in the right direction.

These investments in total enable us to better serve underserved populations at risk, provide faster answers to grieving families, and support our public health system and safety partners across the city and region. Together, these efforts advance our shared mission to address the opioid crisis with innovation and compassion.

Thank you very much, and we look forward to taking your questions.

CHAIRPERSON LEE: Thank you so much for all your testimony. I just want to recognize Councilmember Abreu who's joined us today as well. So, I'm not good at math, so I just was adding on my calculator because I need help with that.

So, if I'm not mistaken, through DOHMH, and please correct me if I'm getting these numbers wrong. So, DOHMH, you guys have a total of $43.4 million. H&H is $22.4, and then OCME is only $4, which I think should be higher. That's just my personal opinion.

And so, if I'm not mistaken, so far we're talking about $69.8 million that have been spent?

DR. LINN-WALTON: The total annual is $50 million, and at this point through FY27, we're ramping up so that all of those dollars will be available.

I know that our portion is $23.7, and I can let the others speak to their totals.

CHAIRPERSON LEE: Okay, so let's go back and dig a little deeper on that one. So, what is the concise overview of how much money New York City has received -- not necessarily spent down, but received -- from opioid settlements to date, and how much has been spent, and the rationale behind the city's current spending strategy?

DR. LINN-WALTON: I can definitely defer to OMB on the specific breakdown of numbers. They had committed to up to $50, that they had an allotment of $50 million annually for 20 years, and so they have dispersed those funds to the three agencies here, and so that we're in the ramping up phase to that total annually.

CHAIRPERSON LEE: Okay, because my understanding, based on reports we have, is that it's so far $154 million.

So, can you guys confirm if that's true?

DR. LINN-WALTON: We can definitely follow up with OMB and confirm the total.

CHAIRPERSON LEE: Okay. But either way, across the board, 50 million annually, I get that part, but then so far, if I'm adding up all the costs to these programs, it's about $69.8.

So, I just kind of wanted to go through a little bit more in detail about the breakdown per program, and also I'm very curious to know about the zip codes and the areas, because as we know, the Bronx and Staten Island-- I know you mentioned Staten Island in your report, but the Bronx also has an incredibly high number of overdose deaths, and so I just wanted to know if we could sort of speak to which neighborhoods and populations are receiving priority.

So, how they're-- Like, which ones are receiving priority, and also how are you measuring whether the funds are effectively reducing overdoses, which you sort of alluded to a little bit, and improving recovery outcomes in those high-need areas?

DR. LINN-WALTON: Absolutely, so why don't I start and then pass it off to my colleagues so they could speak about their own programs.

So, how we're looking at it, all of our programming RFPs are happening, prioritizing those populations with highest rates of overdose deaths.

We also-- All of our relay hospitals are selected in communities of highest rates of overdose deaths, and how we're looking at whether our programs are effective is at a bunch of different levels. We're looking at overdose mortality in those communities. Are we seeing numbers go down? We're also looking at, are we making more connections to care, that the syringe services programs, part of their work is to help get people on to long-lasting care if they want to. Are we being effective in getting people into those programs as well? Are we getting people housing?

We're really trying to look at it from a life perspective, rather than just looking at our rates of overdose going down. So, we are starting to see those numbers go down, but we're also looking at, are we getting enough naloxone kits into those communities of highest need so that we are going to start seeing people? We can't just do blanketed across the city because that may not have enough effect on the South Bronx, which you mentioned, for

example. And so we're looking at, what is the threshold we need to be meeting to get naloxone kits?

And also, most importantly, how are we engaging people who are not currently in treatment through our relay programs, through our SSP programs? We want to be looking at the population who is persistently having non-fatal overdoses. We want to switch that and help them have no more overdoses and be engaged in care.

So, we're trying to look at all of those different factors to see that we're starting to see those numbers go down and why. I hope that answered your question from the health department.

CHAIRPERSON LEE: Yeah, some. And I know that you said you have one RFP that's out and there's a bunch-- What are the-- Who are the partners you guys are working with on the nonprofit side, just out of curiosity?

DR. LINN-WALTON: So we have sixty-- So outside of the overdose settlement funds, we have 65 OASIS-licensed clinics across the city. We have 14 nurse care manager programs.

We have 14 SSPs. And the SSPs tend to be located in those communities of highest overdose rates. And

they really see that as their work, is to have that effect in the community.

We also have, I think, 1,100 OOPs. Those are the programs that are licensed to be providing overdose education and handout kits. And we have 1,100 across the city.

CHAIRPERSON LEE: So can I ask you something? Because I know a lot of these groups were doing the work already to begin with, right? So how are the additional funds being used to strengthen the work that they're already doing, whether it be through the current-- Because I know like there's so many outreach programs. And I had a question later on about SHO, because I'm just very curious with all these flow charts and programs and everything, like as someone who used to navigate folks on the nonprofit side, or in all the city programs that are out there, I got to say it becomes very confusing very quickly. And I think I need sort of a very simplified version of how-- Because my worry and my biggest pet peeve, you guys have heard me say this over and over again, is the silos in the different city agencies and the programs.

And I get that some of it is restricted by state city regulations with OMH versus OASIS and CASAC and all these other things. But-- And I understand that, but I guess if you could just sort of go into that a little bit more in terms of how the additional funds are different or in addition to complementing the work.

DR. LINN-WALTON: Yeah, as a social worker-- I want to-- You want me to-- As a social worker, I'm interested in that too, yeah.

So, some examples are: At the syringe services programs, previous to having this funding, they weren't able to have as many hours. They're also going to be having a one-time investment in infrastructure, so they can do things like mold remediation and have the space be as respectful as we want for New Yorkers. They also are able to do things like build out hot food services rather than serving cold food.

And then also we're working very hard, absolutely, it doesn't matter whether it's OSF funding or not, we want to have better communications so that maybe someone comes for syringe services programs, but they don't want to talk to a substance

abuse counselor, they want to talk to a mental health counselor. How do we know who our community partners are in that community and how does the health department make those connections so that regardless of funding or not, our purpose is to get those organizations talking. And they want that and they keep asking for that. And so that's part of our work is to work with them hand in hand so that for someone who comes in, the full menu of whatever they may want is available for them at the door.

And so the opioid settlement funds have expanded hours, expanded the numbers and types of services and also expanded onsite medication. You know, you used to have to wait to get to an opioid treatment program or another licensed clinic to get quick access to buprenorphine. And through these funds and other funds, we're able to have same day access if someone wants onsite at the SSPs. So, we're really proud of that work.

CHAIRPERSON LEE: Okay, I'm definitely curious to hear more.

In terms of the accountability measures, can you outline the process for auditing and verifying that each funded program is meeting its stated objectives?

And I realize for some it may be early on. And are there defined performance metrics for agencies to report on and how often must they do so?

DR. LINN-WALTON: I definitely will have to follow up on those specific metrics. But yes, for every funded program, we have a system of goals and metrics they should be meeting in order to retain that funding, because absolutely we want to make sure that people are doing what they should be with the funding.

And then also more importantly, when things aren't going well, what's causing that and how do we help them fix that? Because at the end of the day, we'd much rather they fix any issues that are going on rather than remove the funding. So, we have performance improvement when needed, all of those contracting measures in place to help people be effective and do the work they were engaged to do.

CHAIRPERSON LEE: Okay, and I'm assuming that when you do the RFPs or whenever you release the RFPs for the next ones, you will be taking a look at the ones that are already contracted with the city who have proven experience to do the work and then can service those neighborhoods.

DR. LINN-WALTON: Absolutely, yeah. And we definitely prioritize the communities most strongly affected by the overdose crisis.

CHAIRPERSON LEE: Okay, and what mechanisms is this for stakeholders, particularly community-based organizations and individuals with lived experience to provide input on how settlement dollars should be allocated? So, has there been a process for that and where can the public give you all their input on this?

DR. LINN-WALTON: I mean, I'd say we're regularly talking to community providers so that we know that our RFPs are going to meet their needs and desires when they come out.

But I also think we have people with lived experience that we employ who are creating the RFPs. I mean, I know that that's been a central piece to my career is my own lived experience, which I thank you for sharing at the beginning as well, Chair Narcisse, because informing every single decision we do. And we can sit around at a table or virtually or in person, we go out to site visits so that we can make sure we're meeting the needs of communities. We also

have a number of people regularly going to community boards and really having those conversations.

But that said, we can always do better, and we're exploring also ways in which maybe the pandemic meant that we did some fewer meetings with people, and how do we really bring that back in full force?

And I know that we're working on that as a daily work of how can we better engage the public in what we should be doing to better meet their needs?

CHAIRPERSON LEE: And do you also work with the Opioid Fund Advisory Board?

DR. LINN-WALTON: Mm-hmm.

CHAIRPERSON LEE: Okay, and how regularly are you guys in communication with them?

DR. LINN-WALTON: Yeah, so the Health Department has a seat on the Advisory Board and so I regularly attend the meetings.

CHAIRPERSON LEE: Okay, and then can you just give us a more specific breakdown? Because I know that you have a lot of services that you've listed, for example, expanding the syringe services, naloxone distribution, other harm reduction efforts.

Do you have a more specific detailed breakdown of how these funds are divided among specific programs, providers, and contracts?

DR. LINN-WALTON: Yeah, so for the first two years, we had $8.4 million going to OnPoint so they could expand both their hours and the numbers and types of services they were providing. We also-- This year is the big ramp up year, which is why we're really excited to be talking about this work today. So, we're expanding RELAY to two additional hospitals.

We have the Staten Island expansion, that's $3 million. The expansion for SSPs, that's $4.1. We can follow up with the specific numbers as well so that you don't have to do the math in your head, absolutely.

CHAIRPERSON LEE: Yes. No, I can't do it in my head, yeah, no.

DR. LINN-WALTON: I also-- I can't do math in my head very well. So, and then we also have treatment expansion, that's going to be another $4 million. And recovery expansion, that's $3 million.

So, the total increase we're expecting this year is $15.1 million on top of that.

CHAIRPERSON LEE: On top, okay.

DR. LINN-WALTON: We can follow up with those specific numbers.

CHAIRPERSON LEE: Okay, perfect.

DR. LINN-WALTON: And also the RFPs, because we really want the organizations in your communities to be applying for them as well.

CHAIRPERSON LEE: Okay, and we definitely should make sure that everyone knows that these RFPs are coming out and blasting.

I know you guys have your listservs, but yeah.

DR. LINN-WALTON: Yeah.

CHAIRPERSON LEE: Okay, and we've been joined by Councilmember Mealy as well as Councilmember Rivera.

And just really quickly, Local Law 122 of 2022 requires quarterly reporting on opioid settlement expenditures.

Some of the critics have argued that recent DOHMH reports lack sufficient detail. I think today-- Which is why we're having this hearing, because I think this is great. We need more detailed information on where the money's going.

And how do you plan on-- Oh, more particularly, on exact spending levels provider contracts and then

the neighborhood impacts? And so how do you plan to enhance the specificity of future reports that the public can see exactly where funds are going? Is it going to be living on the website somewhere or how can people see that?

DR. LINN-WALTON: Yeah, so just to clarify, the Health Department hosts the OMB reports so that we can report on the entire city expenses. So, we can go back to OMB and talk about what additional information would be helpful. I absolutely defer to them and Law about what needs to be up on it and how to make that clearer for you.

CHAIRPERSON LEE: Yeah, I think it would be super helpful if OMB could sort of distinguish out specifically the opioid settlement funds and the breakdown of that. And then also how that links into, or feeds into rather the current services that you guys already have in terms of improving outcomes in the communities. So, I think that'd be very helpful.

DR. LINN-WALTON: Thank you. Yeah, thank you for that question.

CHAIRPERSON LEE: I'm going to hand it over to my colleagues soon. But just out of curiosity, I know

you guys mentioned a lot of programs, peer support, new programs. Where are you finding-- How are you recruiting folks? Just like-- Because I know workforce all across the board is a huge issue. So, I'd be very curious to hear how you guys are doing your recruitment.

DR. LINN-WALTON: Yeah, I think I'll start very quickly and then turn it over to the recruitment folks and the workforce folks. I mean, for example, we have the peer core and I would really, I would love to have people referred from communities as well. And so, we work constantly to figure out where are our community partners for when we have openings and new programs to recruit.

But I think we could do a much better job of getting all that information out there. So, I think there would be a great possibility of having everyone be more aware of when we're launching new programs as well. So that we want community members to serve their own communities because that's most effective. I know that increases my dedication to the work I do.

And so we want people in New Yorkers to be part of the work. And I'll turn it over to Dr. Schatz.

DR. SCHATZ: Great, thanks. Yes, the workforce is absolutely a difficulty and it's important to acknowledge that there's a national shortage in behavioral health across the system. However, here at New York City Health + Hospitals, we do have a robust portfolio of initiatives to develop our workforce, and it's one of our top strategic priorities because we can have all the money we want, but if we don't have the staff at the end of the day, we're not actually having the program.

So, one example of the many is our social workers and peers for Health + Hospital ran a multi-platform campaign to recruit social workers, and it ran for six weeks across a number of platforms, LinkedIn, Google, et cetera. And it really has picked up the number of social workers that we've attracted and hired.

We also have Peer Academy, which is a really successful service that we have that helps recruit and train community members as well as people with lived experience, which is really critical to our entire program, to help them become state certified peer counselors who can support behavioral health at Health + Hospitals. And we hire over a hundred peers

across our system, which is one of the largest in New York City.

So, definitely an issue. And we try and train up and recruit staff. We're also very innovative and cutting edge. So, people are attracted to the services that we're doing.

CHAIRPERSON LEE: And in terms of capacity, are you guys at capacity? I'm assuming no, right? Because meaning there's still more opportunity for either staffing or peers to get involved in a lot of these programs? You're not fully at capacity, right?

DR. SCHATZ: That's correct.

CHAIRPERSON LEE: Okay. What percentage would you say you have left to fill?

DR. SCHATZ: I would have to get back to you on that.

CHAIRPERSON LEE: Okay, yeah, if you could, that'd be great.

And then in terms of the opioid overdose prevention programs, has DOHMH allocated any money to organizations that are registered as opioid overdose prevention programs? And if so, how much goes to each organization? And how is the amount dispersed to each organization determined? And what is the

process for an organization to become a registered opioid overdose prevention program?

DR. LINN-WALTON: Yeah, I can speak to-- No public funding has gone to the overdose prevention activities. What it is, is we fund the wraparound services of traditional SSP services.

And we have 14 SSPs across the city. Only one of them has an overdose prevention center, but that's just one room within it. And so we're funding the wraparound services that I spoke about before with getting food and access and care and healing. And acupuncture is one of those as well.

So, that's where all of the funding goes to for them. As for federal regulations and becoming an OPC, I definitely defer to the state and federal government on that.

CHAIRPERSON LEE: I have another question. I'll circle around later with that question. And then-- Oh yeah, no, not about that, sorry. A different one.

And in terms of, can you go a little bit more into detail? I know you started going into it a little bit, but in terms of the outcomes and evaluation piece, what are some of the data metrics you're collecting to track the reductions in

overdoses, increased treatment uptake, or improvements in community wellbeing? Because I know you've alluded to some of the outcomes, but then how is it that you're-- What are the metrics you're using to collect that data?

DR. LINN-WALTON: Yeah, so, and just to clarify, were you asking about the OPCs or the OOPPs?

CHAIRPERSON LEE: No, just in terms of the, for example, the syringe service expansions, the public health campaigns, all of that stuff, yeah.

DR. LINN-WALTON: Yeah, so we're looking at the number of harm reduction materials that are handed out, the number of kits handed out, and then the number of engagements in care and referrals and whether people are engaging in that care as well.

So, it's looking at a typical program, you want to see whether it's effective and reducing those rates. And then we're looking at the community level. Are we seeing the numbers go down? And when we're not, is it that we're not meeting everyone who's experiencing overdoses? S,o then we want to layer on, for example, the relay data at the hospitals, because not everyone is engaged in a

program when they're at the point of having overdosed.

CHAIRPERSON LEE: Okay, and also, is there some sort of database that you have on the back end? Because I know obviously we want to protect patient privacy, HIPAA laws, all of that, but is there a database that you guys have on your end that sort of ties in all this information together so that we can better track what's actually happening on the ground?

DR. LINN-WALTON: Yeah, so we do rely on program data. So, we have a database of all their program data. We're not getting client level, for example, on all of our different programs because we want them to provide, they want their own HIPAA protection.

And so we get programmatic data that we then layer on. And the good thing about it, maybe it's not all in the same database, but we can combine different data. A lot of different agencies have this where you combine different data sources to see a picture of whether you're having an effect.

CHAIRPERSON LEE: How are you guys analyzing that? Who's putting that data together?

DR. LINN-WALTON: I have a lovely data team that works in the health department, and they are

incredibly thoughtful researchers who are looking at combining overdose rates in the community and then hospital data and then program data. We work incredibly closely with OCME about their data. We work incredibly closely with OASIS about programmatic data because sometimes they have data we don't.

And we're constantly meeting on a regular basis with different agencies to figure out is the data picture we have full? What are we missing? Where could we get that from? Is there different hospital level data or community provider data that would add to the picture of how things are going? And so we definitely are always working on opportunities to improve what types of data we get and then how we mush it all together into a comprehensive picture of how things are going.

CHAIRPERSON LEE: Okay. I'm going to pause here and hand it over to my colleagues for questions.

So, Chair Narcisse?

CHAIRPERSON NARCISSE: Once again, I have to say thank you for your time, for being here.

Funding allocation: I want to know. New York City Health + Hospitals was earmarked for $22 million in annual settlement funding for fiscal year 2027.

How is H+H distributing this funds among initiatives like addiction counseling and birthing units, specialized addiction response team and other treatment expansion? Do all H+H locations receive the same amount of funding? If not, what metrics are used to determine how much money is being dispersed to each facility?

DR. SCHATZ: Thank you so much, Chairman Narcisse. Your calculations were perfect.

So, $22.3 million annually and then broken down by our mobile harm reduction vans, our SHOW vans, that's $2.2 million. ED leads expansion is another $10 million. The workforce training program that we talked about was $2.4 million. The addiction response teams is $3 million. The addiction counselors and the birthing units that you referred to is $1.2 million. And then our family SUD clinic or our RISE Center that is at Lincoln is $3.6 million.

The way we look at it is we look at where the patients are, who's presenting with what diagnoses, what gaps, what opportunities are available, what the particular facilities need.

For instance, our addiction response teams, those are at the three facilities that didn't have inpatient addiction consult services previously funded through CATCH and now part of our general budget.

For ED leads, that's across the system because we've been hearing lots of positive reports from the patients, from the staff, from the addiction staff and from the emergency medicine staff that they've been really helpful.

And so we want to expand it towards 24-7 and continue to work there. However, as pointed out many, many times here and in the reports, the South Bronx has hit particularly hard and we want to start getting to the under rooting issue of that and intergenerational impact of addiction. That's why we have our family addiction clinic right there.

We look at our numbers, our opportunities and how the clinics are doing and expand as they continue to recruit and retain patients.

CHAIRPERSON NARCISSE: It's just how to make sure that we know where the money goes.

H+H has reported new and expanded programs such as enhanced emergency department coverage and telehealth offerings, virtual express care.

What measurable outcomes have you seen so far regarding overdose prevention, patient's engagement and linkage to outgoing treatment?

DR. SCHATZ: Thank you again for your thoughtful question and we definitely want to make sure we're doing exactly what we pointed out we were going to do.

Health + Hospitals has our ED leads at every one of our 11 facilities and we continue to offer additional hours of coverage outside of the normal tours, as well as over the weekend. All the facilities have some degree of that coverage. A few of them are at 24 seven.

In 2024, there was 24,317 ED leads encounters with over 4,500 referrals to outpatient clinics and over 1,800 naloxone kits were provided.

And I think you asked about the virtual express care, those numbers in one second.

So, virtual express care is the newer iteration of the virtual buprenorphine clinic. It provides 24 seven coverage for any New Yorker who is looking for

mental health or buprenorphine for access for opioid use disorder, either initiation or maintenance.

If they experience a gap in care, which is unfortunately common, the virtual express care is there. You can call, you can talk to a prescriber and a prescription can be written right there.

Virtual express care had over 200 encounters specifically for opioid use disorder in the last six months of last year. And 75% of those received buprenorphine. Those numbers are ramping up as there's more awareness of the program and... yeah.

CHAIRPERSON NARCISSE: So, how you know is-- I mean, how we can know from the data that's coming in that they are our New Yorkers or people can call from all over?

DR. SCHATZ: On intake, it's got to say that they're from New York and we look at where they're currently located.

CHAIRPERSON NARCISSE: Oh, I just wanted to-- okay. Okay. Can you describe the specific protocols for connecting overdose survivors in the ED or elsewhere with MOD, which is Medication for Opioid Use Disorder?

Immediately upon discharge, what data do you collect to ensure individuals actually follow through with the treatment?

DR. SCHATZ: Thank you so much, Chair Narcisse. I was really excited when I heard about your experience in the emergency department and it's laser focused. That is where the patients are engaging our health system, in the emergency department, and exactly as you said, they might come in the throes of withdrawal and if any of us were in withdrawal, we would be acting that way as well.

When you provide patient-centered evidence care, you can take care of their symptoms, relieve their suffering and start talking about long-term engagement. That is a focus of ours and why the Workforce Training Program is doing these live-actor simulations that exactly act out the situation you described, so that prescribers are aware of that and that if you treat it, they'll feel a lot better and you can engage them with care.

So, we're looking specifically at the number of patients who have opioid use disorder, overdose, or coming in with withdrawal in the emergency department and seeing what percentage of them are getting

medications for opioid use disorder in the emergency department, noting that not every clinical situation are they ready for buprenorphine or methadone.

So, depending on that situation, they might not be ready for it in the emergency department either because a patient isn't ready for it or because clinically they're not ready for it.

Importantly, it's not just about the medication in the emergency department, it's about that follow-up. It's why another primary focus of ours is access to care and we can't wait one week, we can't wait a month, we want it to be as soon as possible.

That transition is the most critical piece there. So, we have services that have walk-in services, where direct scheduling-- where this is part of a team effort where the emergency department is very much in touch with our addiction services to make sure when they get the treatment that they follow up in care and that they're maintained there at 30 days, at 90 days and so on.

Furthermore, if they come to the inpatient services, we very much care about a hot handoff. So, it's the same team who might see the patient in the emergency department or in the inpatient unit that we

earn their trust, we say, please see us in the outpatient setting as well.

CHAIRPERSON NARCISSE: One of the problem that I used to face is just weekend and holidays when the clinics are closed. So, are you implementing anything for the followup? Because if you don't implement that, especially on the weekend and holidays when the clinics are closed-- You know, it's personal. I get emotional, because I'm going to remember all my patients in my head right now.

So, what are we doing to make sure those kind of followups-- Because sometimes we call the frequent flyers of the holidays, you know, which I used to hate when my colleagues calling them a name because that kind of like-- I said, "I don't want to be biased when y'all making jokes," so I have to retain that kind of calm. But we know that they existed because they come at that specific time during the holidays and the weekend.

And there's no follow-up. We just drop them out. We just give them-- if we have back in the days, we have a little kind of methadone on the side, we just give-- but there is no real follow-up.

Are you doing a real follow-up right now for our frequent flyers of the holidays and weekend?

DR. SCHATZ: Yeah, as a primary care doctor, I can tell you that those patients do leave that lasting impact on you. And when you can't provide coverage because the clinic is closed, it's devastating because if they go into withdrawal, then they're going to relapse and you lost that opportunity.

So, absolutely, this is a focus of ours. Many of our clinics offer extended hours outside. Our methadone clinics do offer various different services. So usually we can provide coverage as a system that way.

Importantly, this is where virtual express care comes and hearkening back to my own primary care clinic where I'm only there one day a week. They rely on me being there on Wednesday mornings.

And so if they have an issue or if I'm on vacation or something, they can call that virtual express care to make sure they're able to bridge them in that important time.

In the emergency department, a lot of the patients do come on the weekends, at night or on

holidays. We're not only encouraging the administration of buprenorphine and medications for opioid use disorder right in the emergency department, but prescribing in the outpatient setting.

We're using some of those settlement funds to make sure that there's no reason that they should get any of those medications denied, because that's often a barrier in this treatment cascade.

CHAIRPERSON NARCISSE: And we have to know about the reality. Some of them just watch for that, knowing that we cannot get the data that we need to make the right decision at this certain time, unfortunately.

But now the collaboration I hope is better, even with the clinics, like if they can have some numbers. I think the kind of not working together, the collaboration was missing with the clinic.

Let's say if I'm on Elmhurst Hospital, so I have to know which areas that-- which clinics that it goes that nearby that I can call and then get some answers. And we don't double on the medication.

Thank you.

H+H also deploys mobile outreach units and street health outreach and wellness events. To what extent are settlement funds supporting this mobile harm reduction efforts? And how are you tracking their reach and effectiveness in connecting underserved populations to care?

DR. SCHATZ: Thank you once again for your thoughtful question. SHOW Vans are something that's very exciting. It allows us to extend outside of the hospital and reach out into the community, earning their trust where they are and providing whatever direct services we can.

It's very hard to track a lot of the services that they might provide, whether it's like a banana or an apple or just someone who cares, but there is a lot that we look at.

And so just to answer your question for fiscal year 2024 and 2025, $2.2 million are budgeted to the SHOW Vans, which are at Bellevue, Lincoln has two, Woodhall has one, and Elmhurst has another. And they're attached to the facility's safety net housing, safety net clinics, which really prioritize housing.

So, there's a brick and mortar and then there's a van associated with it. Of course, they can refer to our addiction services, but this is part of our medical ambulatory colleagues that they're really attached to. And that's where the physicians come from.

In calendar year 2024, SHOW Vans had over 3,500 encounters. And I can tell you that those are-- there's a lot of repeated encounters. Takes not one encounter, two encounters, but 10 encounters before you earn the trust and help them get referred.

13,000 encounters for calendar year 2024.

CHAIRPERSON LEE: I was going to say, you're not giving yourself enough credit.

DR. SCHATZ: Yeah, sorry. I like to set the expectation here and then... Yeah, we would rather lower it. 13,000 encounters.

CHAIRPERSON NARCISSE: Because if you exaggerated it, we're going to come you and say...

DR. SCHATZ: And if you want patient stories, those are some of the best stories that we hear, because they really treasure that kind of respect and that connection and we earn their trust, and then hopefully get them referred.

CHAIRPERSON NARCISSE: So, my colleague is going to do a follow up, just one second.

CHAIRPERSON LEE: I just had a quick question. So, how are you determining where these SHOW Vans go? Based on what? How are you determining that?

DR. SCHATZ: Yeah, I'm being corrected. There's two at Bellevue and one at Lincoln. I apologize for that.

CHAIRPERSON NARCISSE: No, where do they go? I think that was the question.

DR. SCHATZ: Yeah, so where we go is we look at the demographics of the area where the overdoses are happening. And if there's a specific hot area where there's people at, if there's an acute increase as well as the community asking or needing it. So, we'll identify those kind of areas and sit there for a bit.

CHAIRPERSON LEE: And how often is that data updated?

DR. SCHATZ: I'd have to get back to you on that. It's important—

CHAIRPERSON NARCISSE: So, if you have a crisis, can someone call and they can come to any part or there's a restriction?

DR. SCHATZ: There's a specific location where they are set up. But if we hear of incidents nearby, one of the vans and there's really an increased need, we'll have them kind of go into the community and go over there. But it's important that the vans are at a particular location because a lot of these patients kind of learn to expect where to get that care and to receive it.

CHAIRPERSON NARCISSE: All right. Are you experiencing staffing shortages or high turnover within addiction treatment programs? And if so, how are you addressing these issues to ensure that newly funded programs are fully staffed and sustainable?

DR. SCHATZ: Thank you. As you mentioned previously, this is like a really important piece here. Our initiatives won't happen if we don't have the staffing and there's a staffing shortage nationwide.

We're actually doing a relatively good job and we do have pretty high retention because of the services that we provide. The patients are the ones that keep us connected there. We talk to each of every one of our facilities who are operationalizing this regularly to get updates on what their needs are,

what the highest priority is, if they're having a particular staff type shortage.

We think creatively to see if there's a way to use current staff in other ways or merge lines together to help with the recruitment. We also provide a lot of education. This is where that workforce training program is a lot of people take a lot of pride in what they're doing and want to continue to grow their skills and knowledge set.

So, we're launching a lot of different echo kind of learning collaboratives. So, extension and community healthcare outcome, learning collaboratives where system-wide, city-wide, we're all getting together and feeling like part of a community. That helps with retention and feels supported.

Not too long ago, the addiction leaders kind of felt very isolated. We're lucky at Health + Hospital that we have a huge staff. So, we try to work together as a community, learn, we're cutting edge.

So, we learn from each other faster than the evidence is coming, And so what's working, what's not working, let's morph to what is working.

DR. LINN-WALTON: I just-- Oh, so sorry.

CHAIRPERSON NARCISSE: Yeah?

DR. LINN-WALTON: I had a live update of the annual totals. So, I just wanted to give it to you as well since you had asked for that before. So, for fiscal year 25, it was $41 million. For fiscal year 26, it was $48. And then for fiscal years 27 and 28, it will be $50 million each. So, just to share that OMB is dispersing all of their funds to date over that 20-year period.

CHAIRPERSON NARCISSE: Does H+H have any specific policies regarding the prescribing of naloxone and other drugs aimed at preventing overdose death? What guidelines do you follow when prescribing this drug, and the DOH website indicate-- I mean, indicates that anyone who requests naloxone can receive a prescription for it exempt from needing prioritization from an insurance carrier.

This is a bit complex--

DR. SCHATZ: Thank you, naloxone—

CHAIRPERSON NARCISSE: Because to get the-- Yeah, go ahead.

DR. SCHATZ: Naloxone is a critical piece of our tools to help address patients and just show them that we care. What's important is it's not just for

that individual, but they might be in the community where they can provide it, including their families.

As far as our guidelines, it's give naloxone as often as we can whenever they need it, whenever they approach our system.

So, in the emergency department, we have the ED leads that is regularly giving naloxone kits. On the inpatient setting, we have CATCH staff that are CATCH and soon to be addiction response teams providing naloxone kits. Our SHOW Vans also provide naloxone kits, as well as our outpatient addiction services, but more so than any of that, anyone in Health + Hospitals is able to get access to a kit and be able to provide it to a patient and their family.

CHAIRPERSON NARCISSE: I'm assuming in the mobile unit, you have that too?

DR. SCHATZ: Oh, yeah.

CHAIRPERSON NARCISSE: Definitely, right?

DR. SCHATZ: Absolutely.

CHAIRPERSON NARCISSE: Okay. The H+H website indicates that individuals and group treatment and recovery support services are available as part of the medically supervised outpatient programs. Do

these programs receive any money from the city or the Opioid Settlement Fund?

DR. SCHATZ: They do not. They're revenue generating and city tax levy dollars.

CHAIRPERSON NARCISSE: That was short and sweet. Where are the outpatient CATCH treatments available? Does the tax treatment requirement, I mean, require funding? And if so, does it receive any money from the city or the Opioid Settlement Fund?

DR. SCHATZ: Again, the CATCH teams are also revenue generating and city tax levy as well.

CHAIRPERSON NARCISSE: The consults for addiction treatment and care in hospitals teams, comprised by doctors and nurse practitioners and other medical service providers with addiction, expedite, help patient with substance use disorders. Can you please tell us if H+H employs are all members of a CATCH team, whether these employees serve in the other roles at H+H and whether the maintenance of the CATCH team program is reliant on money from the city or Opioid Settlement Fund?

DR. SCHATZ: So that's the same thing. The acronym you said is the CATCH team.

We hire all of the staff that are there. They provide just CATCH services, unless they're on someone else's budget as well. But for any CATCH time is on the CATCH budget.

They provide not only inpatient services, but also the bridging services. That was that hot handoff that we were talking about.

CHAIRPERSON LEE: No, I was going to say, so what percentage of that is-- Because I know a lot of times, people are part of different programs and the way that the budget is formed is that some of their salary comes from this funding and then some of their salary comes from this funding.

So, for these programs that are not funded, that are more reimbursement based through insurance, how much of that is sort of overlapping with different funding streams versus opioid settlement alone?

DR. SCHATZ: Yeah, none of the CATCH team is funded through the opioid settlement funds. The alternative to the inpatient side is the addiction response teams, which are fully supported by the opioid settlement funds.

On the budgets, most of the non-physician staff are 100% CATCH, most of, I won't guarantee all of them.

But some of the physicians, it's an exciting new frontier that there's more addiction-focused physicians. So, we have a lot of emergency department doctors, toxicologists who are very interested in CATCH and they want to provide some time on the CATCH and some time in the emergency department. And those are usually kind of 50-50.

CHAIRPERSON LEE: Okay, but not through opioid?

DR. SCHATZ: Not through opioid.

CHAIRPERSON NARCISSE: Okay. I'm going to ask last question so I can pass it to my colleague. During the height of the pandemic, H+H offered a virtual-- this word is always getting me— buprenorphine Suboxone clinic that offers harm reduction care for patients virtually, allowing them to participate in a flexible setting. Is this clinic still offered? If so, what services are available through them? How does H+H determine which patients are eligible to be served by the virtual bup clinics? If there's a reason as to why methadone and Vivitrol

are not offered or why methadone patients cannot be accepted to those clinics.

DR. SCHATZ: I deeply appreciate the question and the opportunity to talk about the virtual buprenorphine clinic.

Although that throws us back into the pandemic. I was the one who started that clinic at Bellevue and it was an exciting opportunity where we're all learning about the virtual treatment of addiction.

It was really exciting to learn about the flexibility that can be provided at these services.

And to answer your question about if it still exists. It does, but it's mostly for Bellevue patients because that's where it was focused. Each individual facility and their addiction services can provide virtual services and they do, whether it's telephonic or video. The replacement for virtual bup clinic is now virtual express care because that allowed us to more efficiently provide care in 24/7 coverage. That was not something we were staffed to do at the virtual bup clinic.

To your questions about methadone. Methadone is a specific licensed medication that can only be provided at opioid treatment programs, and need to

have directly observed taking of the methadone and the dispensing of any take home.

So, you need an in-person assessment. That doesn't mean we can't have virtual meetings and appointments in between, but we can't dispense the medication throughout that. Vivitrol or intramuscular naltrexone is a medication that it's an injection. So you need to come in person for it.

CHAIRPERSON NARCISSE: Where would H&H derive funds from to maintain the clinic's availability?

DR. SCHATZ: I would have to get back to you on that. We have lots of ideas and exciting initiatives and we're seeing what's working more than not and where the gaps and opportunities are, of which there's a lot.

CHAIRPERSON NARCISSE: All right, I think you have enough of me. Let me pass it on to my colleague, Ms. Schulman. Thanks.

COUNCILMEMBER SCHULMAN: Thank you very much. These questions are for OCME. Hi, Robert, how are you? Good.

I know you went over some of this in your testimony. OCME receives a portion of settlement dollars to enhance forensic toxicology and overdose

investigations. Can you specify how much has been allocated so far and detail the specific projects or initiatives these funds support?

MR. VAN PELT: Sure. Thank you for the question, Councilmember. So, FY25, there's $4 million in total. That's $2.8 million in PS and $1.2 in OTPS. And I could talk about what we've spent so far of that.

COUNCILMEMBER SCHULMAN: Yeah, that'd be great.

MR. VAN PELT: Okay. FY25, we have spent $1.3 million. That is $897,000 in PS and $402,000 in OTPS, as of December 31st, 2024.

So, specifically, headcount, we have 11 headcount for the DIG, and then we have an additional 17 headcount in support of the opioid fatality result turnaround time. 10 of those 17 have been hired and we are working on the seven remaining.

COUNCILMEMBER SCHULMAN: Okay, great. One stated goal-- So reducing turnaround times. One stated goal is to reduce toxicology turnaround times to provide more timely data to public health partners and grieving families. How have settlement funds been used to advance this goal and what measurable improvements have you achieved?

MR. VAN PELT: Great, thank you for the question, Councilmember. So, yes, that's correct. And I just also wanted to clarify, it's not only to reduce the turnaround times for toxicology, it's to reduce the turnaround time for certifying opioid deaths. So, the overall process-- So, certifying an opioid death relies on toxicology results, but not just that.

It relies on other physical examination and other things.

So, the opioid settlement funds that have been supported have been those 17 headcounts. So, the 11 hired have been towards that. We're already making great progress, as I stated.

So, for the toxicology turnaround time, we're already-- We went from 77 days to just 40 days. So, that's all toxicology results, right? And then the autopsy turnaround time has gone from 118 days, that was in FY 24, to only-- to 84 days presently, right?

So, we're only a few months in, but already we're seeing really great results.

So, we're thinking that these are really great indicators of where we're going to be a year from now.

COUNCILMEMBER SCHULMAN: And what's your ultimate goal for that?

MR. VAN PELT: The ultimate goal-- So cutting in half-- So, really the standard that we aim for is 90 days. That's really the general acceptable standard is 90 days, right? We want to cut the turnaround time to 45 days, certifying opioid deaths.

COUNCILMEMBER SCHULMAN: So, think about-- This isn't what this hearing is about, but think about what resources you might need as we start going into budget hearings and all of that. So, please keep that in mind.

MR. VAN PELT: Thank you, Counselor.

COUNCILMEMBER SCHULMAN: Yes, so the Drug Intelligence and Intervention Group. The DIG aims to gather and analyze overdose data to guide response efforts and offer support to individuals and families affected by overdose fatalities.

What progress can you report regarding DIG's operations and how are these efforts translating into improved prevention or outreach?

MR. VAN PELT: Okay, so again, we're already showing great progress with the DIG. So, we have as of December-- From September 2022 until December

1st, 2024, the DIG has spoken with more than 2,536 individuals who've lost a loved one, right? Of these individuals, 75%, so that's 1,897, 75% have received help in some way from the DIG. And we track that every month we meet and we track those results.

COUNCILMEMBER SCHULMAN: No, that's great. The Family Support Service, the city has indicated that some settlement funds help OCME offer grief support or referrals to survivors after an overdose fatality. Can you describe these services in more detail and explain how you coordinate with other agencies or community groups to provide ongoing assistance?

MR. VAN PELT: Yes. Our social workers have a person-focused way of doing things. They have a wide range of expertise in veteran services, in family counseling, in substance abuse, in substance use disorder, in children, in housing. And so altogether, that helps out with families. I'd like to also turn this to my colleague, Hannah Johnson, who could speak in more detail to the DIG.

[BELL RINGS]

COUNCILMEMBER SCHULMAN: Can I just...? Okay, thank you.

MS. JOHNSON: Yeah, hello, I'm Hannah. I'm the Program Manager for the Drug Intelligence and Intervention Group, so the DIG team.

And so, to say a little bit more about the services that we offer, we do take a person-centered approach. So, when we call families, we say, "I'm so sorry for your loss." And then we just ask, "How are you doing?" And honestly, even that is a really powerful intervention for a lot of people in that they're often taken aback that the government is calling them, asking them how they're doing.

And they often kind of, we hear regularly from families that they say, "Wow, no one has asked me this. No one has asked me how I'm doing," because everyone around them is grieving as well. And so having a person to talk to and to process with is often really helpful.

So, that's why we have social workers making these calls, is because that means that we can be providing that grief support in real time. We don't have to make a referral. You've got your social worker on the phone.

And when we assign cases, we assign cases to the social worker, and then they do the outreach, and

they're responsible for that client from the beginning. So, it's not just like call a hotline, get a social worker. It's call Vanessa, you get her on her cell phone.

She's the one that calls you, you call her back, and all of that. So, we take a really person-centered approach, and that means that we ask them what they need, and then we try to help them with that. And that means that a lot of times people are dealing with the reverberations of losing somebody in their family.

So, that might mean that they have less income as a family. That might mean that their housing is all of a sudden unstable. They may need to move, they may need childcare. There's lots of different ways that this loss is disruptive kind of operationally within the family. And so we will try to help them with those things. We work really closely often to get families things like one-shot deals so that they don't lose their housing.

We work really closely with them on like a whole host of issues that come up. I would say that it is often those kinds of needs that come up, those financial shortfalls that happen after a death. Both

you are dealing with the expenses that come with somebody dying, and you're dealing with like a loss of income for your household.

So, we work with families on that. And then obviously we make a lot of mental health referrals for people. Both our social workers can continue to check in on them and see how they're doing.

We connect people to grief counseling, both individual and groups. I think in overdose in particular, it's a really stigmatized type of loss. A lot of people feel a lot of shame and isolation.

And if they go to a standard grief group, sometimes they'll be turned away because of the, you know, people say this type of loss is too different. We can't help you here. And so, we work really hard to make sure that we're getting people connected to resources and grief groups that understand the specifics of this type of loss.

COUNCILMEMBER SCHULMAN: Great, thank you. How does OCME share critical toxicology data and emerging trends with DOHMH and H+H in real time to inform public health alerts or clinical practice adjustments?

MR. VAN PELT: Great, thank you for that question. So, we meet regularly with our colleagues at Department of Health and H+H.

We also meet with them through the RxSTAT initiative. So, that is, it's a multi-agency group that started in 2012, and now it's up to 30 agencies that work with this. The DIG tracks opioid trends, suspected opioid death trends and prior to death certification.

And we share those trends with our colleagues. And so we meet regularly with them and we talk about program initiatives and trends and ways to not duplicate efforts.

COUNCILMEMBER SCHULMAN: Okay, according to the 2024 Mayor's Management Report, the median turnaround time for toxicology cases increased between FY23 and FY24.

The report cited the increase of overdose deaths and a record increase in post-mortem cases being submitted to the Forensic Toxicology Laboratory for toxicological testing as contributors to this lag. Aside from the increased caseload, what factors are contributing to these declining numbers for turnaround times? And can you please tell us the

number of staff who are employed at the Forensic Toxicology Laboratory and the workload that they are subject to?

MR. VAN PELT: Thank you, Councilmember for that question. Yes, so in 2024, there was an increase in turnaround time for toxicology. So that was correct. It was due to the increased caseload, but also toxicology was undergoing a new accreditation. It's an advanced accreditation that's required now. It's the International Standard ISO 17025. I had to write that down.

So, in becoming accredited, it required taking off a lot of the criminalists from their regular bench work to work on accreditation, work on the equipment, and so that as a result also contributed to the turnaround time increase.

Now we're fully accredited. All the criminalists are back to their bench work, and we anticipate-- well, we've seen already that toxicology results have gone down. Additionally, through the Opioid Settlement Funds, we received a headcount about eight additional criminalists for Toxicology Lab. We've hired seven of those.

So, we're headed in a good direction. We have a total of 41 staff in toxicology and about four vacancies total.

COUNCILMEMBER SCHULMAN: Four vacancies, and what are you doing to fill them?

MR. VAN PELT: We are recruiting through nyc.gov, and we also, we have-- So, with OCME, because we have such a specialized focus, it's more difficult to recruit forensic scientists and that, but we're working on it. We're interviewing actively. We have open house events, Forensic Science Week, where we invite students from colleges to come in and see what we do and get them interested in us.

So, we're confident by the end of the year we'll have those vacancies filled.

COUNCILMEMBER SCHULMAN: All right, thank you very much. Thank you, Chair.

CHAIRPERSON LEE: Thank you. Just wanted to ask a clarifying question. Sorry. So, just in terms of how the funding is going to be reported, so because I know that in Appendix B, for example, you have OMB, the New York City Department of Health and Mental Hygiene, New York City Health + Hospitals, OCME, and

then you also have the community-based organizations that were selected through the procurement process.

So, I know that you sort of outlined it here in terms of some of the breakdowns of the funding, but then is that going to be more specific in terms of the last bucket with the community-based organizations?

I know you sort of were telling us, but I just want to make sure that this is, if I'm understanding correctly, that hopefully this diagram will be tied to numbers in a more specific breakdown, if possible.

DR. LINN-WALTON: Yeah, so just referring to OMB notes, since I definitely defer to their expertise over mine, per LL 122 of 2022, OMB and mayoral agencies were required to report to city council after the release of each financial plan on the city's use of opioid settlement funds, and the health department provides information to the council through this regular reporting. The last report was published the week of January 24th, and then the subsequent reports will include updated numbers as those numbers are dispersed.

CHAIRPERSON LEE: Right, but is it going to be broken down in this manner, or how would it be broken down more specifically?

DR. LINN-WALTON: We can definitely follow up with the specifics of the report.

CHAIRPERSON LEE: Okay, that would be great. Perfect.

CHAIRPERSON NARCISSE: Okay. Collaborating together. So, are you coordinating your effort to avoid duplication of services, and you can't do it efficiently?

DR. LINN-WALTON: Across the agencies or across the city?

CHAIRPERSON NARCISSE: Yes.

DR. LINN-WALTON: Absolutely, I think we meet on a regular basis to talk about all the work we're doing. I mean, I think the best example was over the summer, we were noticing an uptick in new substances entering the unregulated supply, and so we immediately got on the phone, figured out who had which piece of information, how can we coordinate across the community programs, and a great example of that was that we figured out that since there were non-opioids in the system, rescue breathing was much

more important than it previously was, and so we immediately started doing trainings that included more rescue breathing and putting those materials into the naloxone kits for people as well.

So, I think that's a great example of how we're regularly talking about what our overall strategy is, and how we figure out what those gaps are, and I'll definitely turn over to my colleagues too.

DR. SCHATZ: I agree with all of that. I also-- Fentanyl and xylosine test strip distribution is really important. I'd also say that, as I mentioned before, the evidence around addiction is lagging behind what's happening in the drug supply. There's huge amounts of resources, so we're cutting edge in a lot of ways, so learning what each other are doing, what can we learn from Relay, what can we learn across RxStat of what other programs are doing for specific populations.

Unfortunately, there's a lot of need out there, so we're not stepping on any feet, but it's trying to think how we can optimally provide the services, and I think our collaboration is frequent.

CHAIRPERSON LEE: And then also, are you coordinating with a lot of the other-- For example--

Because I know that with mental health and substance use, there's a lot of comorbidity there, so are you also coordinating with the other outreach teams like the ICT, ACT, IMT, all the other ones that are out there? BEHERD.

DR. SCHATZ: I can take from a Health + Hospital standpoint, we all fall under one roof in the Office of Behavioral Health, so that makes it a lot easier.

So, there's the mental health, and there's the addiction services. We talk frequently to each other, we try to make sure that we're seen as one and the same. And especially in addiction services, it crosses over not just mental health, but medicine, the emergency department, adolescence, OB, so we are frequently having to do interdepartmental work and efforts. The workforce training program in particular is focused on behavioral health staff, that's the 3,000 staff that we'll look to train.

So, for our mental health colleagues in our office, we'll be providing them the earlier-- more than basics of addiction services, but we're also providing the addiction team the mental health services, and we very much look for that crossover co-occurring disorders.

CHAIRPERSON LEE: And then how about in terms of the providers on the ground? So for example, ICL, right? If I come in and I'm a homeless person that's experiencing a mental health breakdown and I'm also addicted to opioids, how-- If it's coming from the provider side, do they have access to sharing those databases? I mean, I come-- I'm asking this with sort of knowing what the answer is, but I guess the point I'm trying to make is how are we making sure that I as a whole person, no matter what access point in the system I'm entering, whether it's a hospital, inpatient, or an outpatient, or on the street, how are we making sure that there's some understanding of whoever's treating me at that moment? "Oh, this person has actually been in services before at Bellevue," or "this person has actually been in the inpatient care through Elmhurst," because we keep seeing this revolving door. So, I guess I'm just trying to understand how we're better catching people where they're at.

DR. SCHATZ: Yeah, it's the focus of, we want to meet the patient where they are, what they need, when they need it. We can't vary on any of those three different items there. And these individuals are

often moving around because of whatever shelter they're in, the current location.

So, they might be at one Health + Hospital versus another. Unfortunately, with HIPAA and 42 CFR, we really have our internal H+H data. But within there, what's nice is we had recently transitioned over to Epic, and it's much more data-driven, and we can see any of the encounters and make sure that you have access to that.

You might need to kind of what's called break the glass to say that, yes, this is important for the patient care for me to be able to see this and access it. But we definitely think of that way.

Now, we also want to train the staff appropriately to what's needed. So, we need to access what's the immediate needs, act on that, but we also need to screen and how far down the screening algorithm do they go? And what kind of intervention can they provide rapidly at that point versus the referral and the followup? And we make sure that the right person is getting that kind of training and making sure at the end of the day, the addiction services at large is always available for

consultation, either indirectly, like through communication, or directly with a referral.

CHAIRPERSON LEE: Are the other outreach teams allowed to have some of these kits? Do they, I'm assuming they're equipped with some of these kits also, right? In their units?

DR. SCHATZ: Yes, they are.

CHAIRPERSON LEE: Oh, right. Sorry. Just my one final question is, and I know you sort of all alluded to this earlier, but in terms of the demographic breakdown in terms of which populations are-- Because according to the data and the reports, it seems like white versus black Latino populations, we see that there's a decrease in the opioid cases in the white population, but not in the black and Latinx population. So, I'm just wondering, what is the department and agency specifically doing more in terms of reaching out to those folks and targeting them? If you could just go a little bit more into detail.

DR. LINN-WALTON: I can start and pass it along.

I think we're all equally focused on why we're not seeing the same decrease in all populations across the board. And so, some of that work is

working with researchers who are helping us figure out, do we need more kits into the communities? Are we working with the right community providers, with faith-based organizations? Where are people that we're not currently engaging in our existing services that we're contracting with? And how can we better meet their needs? So, we're working with coalitions, we're working with community providers. Our community programs, some of them are here, and they're very not shy about sharing with us.

Populations, we're not meeting their needs directly. And so, we want to hear that. And so, we want to adapt to meet their needs. Are there new organizations we can engage with who may not be providing services, but they are meeting people who are experiencing overdoses? And so, we can offer naloxone kits in churches, offer naloxone kits in employment services, and have those conversations, and then have those referrals ready so that people can get them as well. Because we don't want someone to be struggling with the whole of having to respond to overdose if you're, say, a church, that's not your mission. And so, we want to have their ability to come to us with additional supports needed as well.

CHAIRPERSON LEE: Yeah, and this is where I think the community partnerships are super important, including what you touched upon, which is the religious institutions. Because I've had a lot of, for example, folks in various different religious groups across the city say, "Listen, this is so taboo in our community, and so we can't even talk about it in our communities. But we know that our kids are struggling with this, and it's happening." So, I think they really are struggling with this. And I'm just wondering, because obviously when we say black or when we say Asian, there's such a diverse group in that. And there's a lot of languages spoken.

So, is it that we're not hitting up the right community partners that sort of have these reaches into the hard-to-reach communities? Or what is-- Do you have a sense of what that is? What the issue is?

DR. LINN-WALTON: Thanks, it's an important question that we're struggling with, too. It's all of the above. It's sometimes that we're not reaching the widest range and different types of people within one community who have different affiliations and identities.

Are we not doing-- We're working closely with the school system, too. Is there updates we need to be doing to the types of information we're sharing? For example, now that cannabis is legal, how we're talking to parents about keeping any edibles or other supply they have safe from children, and having honest conversations that if you know it's in your house, you need to be having that conversation with your kid about it as well. And so we're constantly trying to think about, is it something as simple as not the right languages? Are we not in the right spaces? Are we not using the right language to talk about what we're experiencing and what other people are experiencing as well? And so we have a rapid assessment and response team who are out in the communities figuring that out, and then they're working with community providers as well to adapt to their language and how they talk about it as well.

And so, I think it's this constant feedback between us and the community experts to adapt what we're sharing out as well.

CHAIRPERSON LEE: Okay, great, thank you.

CHAIRPERSON NARCISSE: I want to say thank you for your time.

CHAIRPERSON LEE: Yeah. I appreciate it. I think that's it on our end.

We're going to move into the public testimony section, but thank you, and we'll definitely send up the follow-up questions that we would love to try to get more details on, but really appreciate your time.

CHAIRPERSON NARCISSE: Thank you.

DR. LINN-WALTON: Thank you.

[2 minutes silence]

CHAIRPERSON LEE: Okay, so-- Oh, sorry, sorry. I don't want to interrupt your chit-chat, I feel bad.

Okay, so I now want to open up the hearing for public testimony, and I want to remind members of the public that this is a government proceeding and that decorum shall be observed at all times.

As such, members of the public shall remain silent at all times. The witness table is reserved for people who wish to testify. No video recording or photography is allowed from the witness table.

Further, members of the public may not present audio or video recordings as testimony, but may submit transcripts of such recordings to the Sergeant-at-Arms for inclusion in the hearing record.

If you wish to speak at today's hearing, please fill out an appearance card, if you have not done so, with the Sergeant-at-Arms, and wait to be recognized. When recognized, you will have three minutes to speak on today's oversight topic.

If you have a written statement or additional written testimony you wish to submit for the record, please provide a copy of that to the Sergeant-at-Arms. You may also email written testimony to testimony@council.nyc.gov within 72 hours of this hearing. Audio and video recordings will not be accepted.

We will hear, actually, the Zoom testimonies first. So, if all of you guys who are on Zoom, if you could prepare for us to unmute you. And I believe, first up, we have our dear colleague, Brooklyn Borough President, Vanessa Gibson.

BOROUGH PRESIDENT GIBSON: Thank you so much. I am Vanessa L. Gibson, the Bronx Borough President. And I think all of you--

CHAIRPERSON LEE: Oh, sorry, I was reading out loud the thing. Sorry about that, oh my God, BRONX Borough President, my bad.

BOROUGH PRESIDENT GIBSON: That is okay, that is okay. We love Brooklyn Borough President, Antonio Reynoso. But thank you so much, everyone. Thank you to our Chair, Linda Lee, and Chair, Mercedes Narcisse, and all the members of the City Council's Committee on Hospitals and Mental Health, Disabilities and Addiction.

Thank you for convening such an important hearing this afternoon. Sorry I could not join you physically at City Hall, but you know I'm always there in spirit.

I just wanted to speak on behalf of today's topic and the importance that it plays for my borough of the Bronx. We are seeing firsthand the effects of the opioid epidemic and what it's done to our communities. Many of our families and individuals that are living with opioid misuse and drug addiction. And while we are so grateful that there is a decline in overall fatal overdoses in 2023, I remind all of my City Council colleagues that the Bronx, unfortunately, continues to see an increase in opioid-related fatalities.

Our overdose death rate in 2023 was nearly twice that of the next highest borough, further

highlighting the disparities that we face that continuously persist in addressing this public health crisis and call to action and attention.

The situation is untenable, and we know that more must be done at all levels of government to bring relief to the Bronx and the City of New York and many communities that are impacted by the opioid epidemic. As our borough and our city continue to confront this unprecedented opioid epidemic, we've received very little in the form of the Opioid Settlement Fund.

And I want to thank our Attorney General, Letitia James, and her team for her leadership on this critical issue and for fighting to ensure that all of our communities that have been the most impacted by this crisis can now receive the financial support and the programs that are needed to invest in social services, harm reduction, drug treatment programs, and real comprehensive strategies that work, that are documented cases of success and organizations who are on the ground and have been on the ground for quite some time.

So, in our testimony today, we are calling on the mayor and the Adams Administration to provide full transparency on how these funds are dispersed and to

really create a plan to equitably distribute the funding to many neighborhoods across the city and certainly in the Bronx that have been impacted the most by the epidemic. What we've heard for many service providers on the ground today and community residents in the Bronx are on the conditions that you see today.

Right now in the Bronx, if you take a trip to The Hub, the South Bronx, 149th Street, 3rd Avenue, the Melrose area, Southern Boulevard, Kingsbridge Road, Fordham Road, major commercial corridors, you will see syringes and needles. You'll see individuals that are actively shooting up and using drugs in our streets, where children, where older adults, where pedestrians, where commuters, and everyone is really traveling and they see this all the time.

Our children and families are sometimes forced to see that in plain view, active drug users, potentially dangerous individuals who are using syringes and other things as they walk around our neighborhoods.

This is unacceptable to me. It's unacceptable to all of us. I know you agree.

And it really requires a holistic approach to how we address the root causes of these issues. When we talk about healthcare, mental health, the work that the Department of Health and Mental Hygiene is doing, as well as Health + Hospitals. We cannot ignore the years of healthcare injustice that we have experienced in many of our communities and we can really address them head on now.

With the Opioid Settlement Fund and the millions of dollars at our disposal, we want to make sure that the Bronx is protected, we are respected, we are valued, and we are included in this process.

Sanitation, NYPD, Parks Department, they do phenomenal work picking up needles, syringes, underpasses, overpasses, parks, playgrounds. They do as much as they can, but the volume is so heavy that we simply cannot keep up with what is happening.

And so, the funds from the Opioid Settlement Fund really must be allocated to those service providers and the organizations, I call them credible messengers, who are on the ground and work directly with the population that we're talking about. In a culturally sensitive way, language diverse, and continuity of services, they are tailored to meet the

needs of the clients that they are serving today. And so the Bronx cannot wait.

We need this money, we need the funding right now, and every life we lose is a reminder of the work that must be done. We've had far too many overdose deaths in our borough. We're working so closely with health and hospitals, Lincoln Hospital specifically.

We've allocated $2 million, along with $4 million from the state, to incorporate a new bridge clinic in Lincoln Hospital on the sixth floor to provide referral services from the emergency room and to centralize all the existing services in the South Bronx, which has historically been saturated with many of these social service programs.

So, that is a part of the challenges that we're facing in The Hub, and we're working so closely with the Third Avenue BID, the Southern Boulevard BID, all of our business improvement districts, because businesses are complaining. They want to work and operate their businesses in a place that's safe, that's clean, and not exposed to the needles that they're seeing.

And so we must use this opportunity and this funding to really look at creative and innovative

solutions. And I look forward to working with both of you, Madam Chairs and the City Council Speaker Adams, to make sure that we really, really sound the alarm.

The Bronx needs this money. Whatever process we have to follow, working with our health partners, we will do that. But most importantly, we do not want to be left behind. When it comes to overdose deaths, the Bronx facing the highest, we can do something about it.

And I don't want these deaths to be in vain. I want the loved ones and the family members of those who have lost their battle to this addiction to know that we are here to help them and support them every step of the way on their path to healing and recovery. There is a way out, and there's always light at the end of the tunnel.

And so I thank you so much for the opportunity. I hope you know you have a partner and an ally in the Bronx Borough President. We will work with you when it comes to policy and budget, but most importantly, the Opioid Settlement Fund is so critical to this work.

And we want to make sure that the Bronx is protected and that we are included in this process. And we need this money like now, like ever before. So, I thank you so much, Chairs.

Thank you, Chair Lee. Thank you, Chair Narcisse. And we look forward to working with you.

CHAIRPERSON LEE: Thank you so much, Borough President Gibson. And of course, as always, reiterating all the points, bringing the fire, amen to everything you just said. And this is exactly why we're having this hearing because we want to make sure that the money is going towards the zip codes in the neighborhoods and areas where it is most impacted.

And that was the intent of this funding was to have that money go back into the communities. And so I'm hoping that with this report, we'll be able to see a much more detailed breakdown by zip code in terms of how those neighborhoods are being serviced. And definitely, we'll call upon you in the future, near future to partner with you on this because it's a huge issue.

So, thank you so much for all your advocacy.

BOROUGH PRESIDENT GIBSON: Absolutely.

CHAIRPERSON NARCISSE: And thank you for being present to advocate when they said, the union said, when you fight, you win. And I love your fighting spirit.

And we know the zip code, sometimes people kind of neglect some areas that needed the most. So, that's what we did. And Chair Lee had asked about that question, the zip code, which is important and how those mobile units are going, how the service, how the data's coming in to say that there's improvement.

So, thank you. And the collaboration with the people on the ground that knows the community best, like yourself, you know, like just the back of your hand, like they used to say. So, I hope you're collaborating with you as well.

So, thank you.

BOROUGH PRESIDENT GIBSON: Thank you. Thank you so much, Chairs.

And I will just finally add that what we've done in areas of great concern, like Kingsbridge, the underpass was a source of syringes and needles. And we really had to develop an interagency coordination because we realized the service providers needed

help, but the agencies needed help. So, we had NYPD, we had Boom Health, we had some of our FQHCs, we had some of our other providers from sanitation, the parks department, DOT, elected officials. It was all hands on deck. And what I've seen now in The Hub is really a situation that's spiraling out of control. It is really bad in the South Bronx. And I definitely need to make sure that organizations like SACHR, the St. Anne's Corner Harm Reduction, and Samaritan Daytop and many others that are a part of this work, I really need to make sure that they get the support. Because sometimes you have cases where there's an RFP, there's some sort of a competitive process, and then our Bronx providers are left out, or they are not in the competitive bidding process.

So, I do want to make sure that whatever process we come up with, there's an equitable distribution, and there's a recognition of those that have been on the ground.

The drug epidemic started back in the 70s and 80s for a reason, right? And we got our way out of that, and now we're seeing the nuance with opioid, with fentanyl that's happening. Look at what happened in one of my daycare centers in the Bronx last year.

And so this is a real call to action and a real threat on our health and public safety.

And so I'm so grateful that we have allies like the both of you in the city council. While you represent Brooklyn and Queens, you also represent the Bronx too. So, I just say thank you for your support, for your partnership, and to our health partners. We look forward to this work ahead. Thank you so much.

CHAIRPERSON NARCISSE: And in addition, life experience matters. For Chair Lee has been in the movement for a long time, and as well as myself being a nurse. So, thank you.

BOROUGH PRESIDENT GIBSON: Thank you so much. Thanks, ladies.

CHAIRPERSON NARCISSE: Okay, great. Thank you so much.

And next we have Christine, and forgive me if I'm mispronouncing, Christine Khaikin, followed by Bennett Allen.

MS. KHAIKIN: Thank you so much. Actually, that was perfect.

Thank you to the Council Committee on Mental Health Disabilities and Addiction and to the

Committee on Hospitals for holding this hearing and the opportunity to speak. My name is Christine Kaikin, and I am a Senior Health Policy Attorney at the Legal Action Center, a law and policy organization that has been working for 50 years to achieve equitable, accessible and affordable services for people with substance use disorders and people who use drugs.

As advocates in this field, we've been fighting to ensure that dollars collected from opioid manufacturers, distributors and pharmacies in the lawsuits actually are used to address the overwhelming public health emergency of the overdose crisis.

There are many examples across the country and right here in New York State of funds being used inappropriately to buy police cruisers or for punitive abstinence only programs, or even to sit in bank accounts collecting interest. That is why we and so many organizations have been working to monitor where these funds go and push decision makers to use the money to save lives now.

We've been gratified to see some of New York City's millions of dollars in settlement funds be

used to expand critical programming that is shown to work, like the nation's first two overdose prevention centers and expanding syringe service providers programming. Both of these are proven to work and desperately need funding, especially during this new federal political climate.

Additionally, funding that supports connections to care for people who want it in emergency departments and for birthing and postpartum individuals who need care at all these are all really important places to spend the money. And we commend all the efforts discussed today by DOH, MH and Health + Hospitals.

However, we want to join the voices of those who have been concerned that this information is too limited to fully and accurately understand where the money is going. Broad stroke summaries of programs available to the public so far aren't enough and leave open questions of whether any of these funds are going places not included in reporting. And it's also impossible to evaluate whether these settlement funds are being targeted to communities that need it most, like the Bronx where the overdose rate is more than twice that of Manhattan. Black and Latine

individuals are deeply suffering from this crisis. But there's little to no way to evaluate if they are receiving the bulk of these funds.

Information about the CBOs receiving funds and implementing programs is similarly unavailable. And so without transparency, it makes it hard also for the state's advisory board to coordinate spending, to avoid inefficient overlaps or to send money where they can bolster spending if needed. The most effective way to do this is to create public facing spending dashboard that is regularly updated to allow real or real time monitoring.

We applaud the council for passing legislation to require more reporting about the spending and for holding this hearing today to get more information. And we support efforts to follow the trail of these dollars to ensure they go where they're needed.

Thank you so much.

CHAIRPERSON LEE: Thank you. Okay, and next we have Bennett Allen.

MR. ALLEN: Good afternoon, Chairs Narcisse and Lee and members of the Committee on Hospitals and Committee on Mental Health Disabilities and Addictions.

My name is Bennett Allen and I'm an Assistant Professor of Epidemiology at the NYU Grossman School of Medicine, where I've dedicated my scientific career to the study of overdose prevention. On behalf of NYU Langone Health, I'd like to express our gratitude to the committees for holding this joint hearing and our appreciation for the opportunity to testify.

The city's opioid settlement funds present a rare opportunity to bend the curve of the epidemic, eliminate disparities in overdose by race and by class and make our city healthier, safer and fairer for all New Yorkers.

I'll now outline some approaches that NYU Langone Health recommends the city take to invest in science, health and equity.

In the short term, the city could invest in life-saving overdose prevention and response services focused on harm reduction, which include tools like the overdose antidote Naloxone, testing strips for xylosine and other adulterants and education about safe reuse. For example, settlement funds could bolster and increase the city's path-breaking investments to integrate harm reduction services

throughout the shelter system, as overdose is the leading cause of death among homeless New Yorkers.

In the medium term, the city could build on its substantial and commendable investments in the evidence-based treatments methadone and buprenorphine, which are our two best treatments for opioid addiction. Settlement funds could increase the availability of these medicines through innovative pathways like mobile services or co-locating these treatments in supportive housing.

And in the long term, the city could prevent future crises through broad-based investments to strengthen the social fabric of New York. This can include investments in housing, poverty alleviation and education. Settlement funds could support innovative and reality-oriented prevention programming for youth and young adults to make sure that overdose prevention is available widely and early to New Yorkers before addiction progresses.

In summary, the city should really seize this opportunity to weave together and strengthen our city's existing infrastructure to end the epidemic and protect the most vulnerable New Yorkers.

On behalf of NYU Langone Health, I just want to thank you for the opportunity to testify. So.

CHAIRPERSON LEE: Thank you both. And I may just be following up with you all just to get a little deeper on some of the suggestions that you've made, because I do think that there's a lot of merit into the suggestions that you guys have testified to.

And so I just wanted to thank you both for waiting online and for testifying with us today.

Okay, and now we're going to go to the in-person panel.

So, I'm going to call up everyone at once. So, we have Erin Verrier, Terry Troia, Anne-Marie Foster, Stephanie Marquesano, I'm sorry. My eyesight is failing me at this point, and Gia Mitcham.

And I just wanted to encourage you all, because I know you guys are all amazing community leaders and partners. So, we will read the testimony, but I'm really curious to hear from each of you what actually is happening on the ground based on what you're seeing, and also what some of the improvements are that we can think of either on the city council side that we can either legislate or try to push for on the administrative side.

So, I'm very just curious to hear your thoughts on all those things. And of course, your testimony.

We can start with Erin. Is she here? Okay. Then Terry? Okay.

REV. TROIA: Wow, I never go first. My name is Reverend Dr. Terry Troia. I'm the President and CEO of Project Hospitality.

We work with homeless people in the borough of Staten Island for the last 40 years. I've worked with homeless people in the borough of Staten Island for the last 40 years too. I'm representing not only my agency today, but the Staten Island Partnership for Community Wellness, Tackling Youth Substance Abuse Coalition that has been working on the front lines of reducing youth substance abuse in our borough.

And I am also a part of the Staten Island Overdose Task Force that's led by our borough president, Vito Fussella, and our district attorney, Mike McMahon, and we produced a very large report earlier in 2024.

I just want to show you, if you'd like show and tell, that this is Staten Island and this is the north shore of Staten Island, which is predominantly

people of color, and this is the most overdose deaths in Staten Island. So, even though we are a predominantly white borough, this is the population that is predominantly affected by overdose deaths.

When the first round of opioid settlement dollars came to New York City, Staten Island was left out of the allocation. The four boroughs got the allocation. We can't count in the city of New York.

So, there was a lot of hooting and hollering that happened upon our elected officials, most notably our New York State Assemblyman, Sam Pirozzolo, who most people may never have heard of, who led the charge to get the opioid dollars into Staten Island. We received $12 million of the $154 million, which represents 7.79%, which is about $3 million a year, $3 to $4 million a year over the next three years. And it's being distributed to eight substance abuse treatment providers or harm reduction providers in our borough.

We are very grateful that we have been able to expand clinic days, clinic hours, and actually to put some clinics in the south shore of Staten Island where we have a significant drug overdose problem, but where it is not as well acknowledged publicly.

Further, Staten Island is the only borough in the city of New York that does not have a Health + Hospitals hospital. And so we have depended over the last three years for the SHOW Van to connect our people with care in Coney Island, which is where people have to go for ongoing services. That's in the borough of Brooklyn. And it's very hard to get there by public transportation.

There are thousands of people, low-income people working poor on Staten Island who do not qualify for public health insurance, who rely on health and hospitals, one clinic on Staten Island, when we used to have three, and one hospital, Coney Island in Brooklyn, for all their care.

The SHOW Van was magnificent for the three years that we had it, being able to expose homeless people who didn't have public health insurance to some kind of connection to treatment and care, specifically with the harm reduction, but also with the primary care that was a part of the SHOW Van. The SHOW Van funding ended for Staten Island on June 30th of 2024, although it continues in the other four boroughs. And for six months, we have had biweekly meetings with our deputy mayor, Isom Williams, and with Dr.

Ted Long from Health + Hospitals to get the SHOW Van reinstated.

At this point, they have absolutely said there's no money to give the SHOW Van to Staten Island. What I learned today was very eye-opening, may I say.

[BELL RINGS]

And instead, they're going to give us a transport van and a driver to drive people to Coney Island in Brooklyn to get services.

Whatever we could get, if it's got four wheels and we have to do that, we will do that.

But you need to know that people are dying on the streets of our borough, even if nobody says it in the newspaper. And we are continuing our discussions and with Dr. Ted Long.

Most recently in December, I put another proposal together with him and I'm waiting for feedback from Health + Hospitals.

A transport van is a consolation prize. A SHOW Van would really be helpful, but it's $2.2 million per van versus $300,000 for a van and a driver and an escort to Brooklyn.

Let me tell you something about the people that are dying.

There is a man named Daniel. He was 29 years old. He was the first person I met with COVID. He was passed out on the sidewalk in March of 2020. I didn't even think he had COVID. I picked him up, I put him in my car and I drove him to Richmond University Medical Center where he was diagnosed as one of the first cases in our neighborhood with COVID. A couple of years later, I took him to Health + Hospitals Clinic on Staten Island for his first visit with a Western doctor after his experience in the hospital where he got his first TB test. He spoke Mixteco, he was an indigenous person and it was very hard to communicate with him and he had some intellectual impairment. On January 15th of this year, he died in the park across the street from my office.

He was one of the first people on the SHOW Van, the first person connected with care in our neighborhood and that SHOW Van's gone and he's dead, and he was a very lovely human being and I just want to say in closing, what was his life worth? $154 million.

CHAIRPERSON LEE: Thank you, Terry, for that testimony.

So, as you were testifying, Chair Narcisse and I were just looking at each other because we, this is something that I personally think we should--

CHAIRPERSON NARCISSE: Talk to our colleagues.

CHAIRPERSON LEE: Oh yeah, yeah.

CHAIRPERSON NARCISSE: Whoever represents that side, we're going to have to have a conversation.

CHAIRPERSON LEE: Well, not only that but also on the city side, on the administrative side, that's a capital-- Because that kind of van would be a capital request that we could try to see if we can push.

I mean, I'm not making any promises. I hate over-promising and under-delivering, but...

CHAIRPERSON NARCISSE: We will talk to our colleagues as well.

We'll talk to our colleagues as well. Yeah. We'll talk to our colleagues as well.

REV. TROIA: I appreciate it. And Deputy Mayor Eisen was on our side.

CHAIRPERSON LEE: Yeah, yeah, she's great, yes.

REV. TROIA: She was putting H&H's feet to the fire.

CHAIRPERSON LEE: No, she's good, yeah. And so we'll continue to see what we can figure out on our

end because as we know, based on the reports, it's Bronx and Staten Island that have the highest overdose rates in the city.

So, we need to make sure that if that's what the data is saying, then logically speaking, that's where the resources should be going according to the settlement funds.

And so we'll circle back, but thank you.

Three overdose deaths a week. A week. About 150 a year.

CHAIRPERSON NARCISSE: Wow, all right.

So, thank you so much for sharing. Thank you very much. We'll work on it.

REV. TROIA: Appreciate it.

CHAIRPERSON NARCISSE: And you're going to hear from us.

CHAIRPERSON LEE: And I just want to recognize Councilmember Louis has joined us and is taking her time out from her own hearing that she's chairing, so thank you.

Okay, so Anne-Marie Foster, go ahead.

MS. FOSTER: Hi, good afternoon to our city Councilmembers. Honorable Linda Lee, Honorable Mercedes Narcisse and Schulman is no longer with us.

I am very happy to be here to be able to testify. My name is Anne-Marie Foster. I'm the President and CEO of Phoenix House.

I will not read my testimony. As you suggested, you have it on the record. I do want to point out just a few highlights and happy to answer any questions.

First and foremost, let me tell you a little bit about Phoenix House. We've been around since 1967. We help individuals recover and lead healthy and productive lives.

We offer short-term and long-term residential treatment, intensive outpatient, general outpatient, and we also work with individuals with co-occurring disorders. We have various programs for both adults and adolescents throughout New York as well out in Suffolk County and Long Island. And we also provide educational and sober recreational support for both the individual, their family members and significant others.

I'm here today to testify and this was very important to me. Since New York City received opioid settlement dollars, we have not received one dollar. And I am happy to-- I can say I sit on several

committees that represent organizations throughout the city as well as the state and it varies.

And many individuals in our position as CBOs have not received any funding from the opioid settlement dollars. It was quite interesting to hear the testimonies of our colleagues.

I will say there are conversations. We have been working towards it, but the dollars have not flowed to the organizations that need it.

And so just a couple of highlights I'd like to bring to the attention of the committee. First, access to these dollars, despite the significant amount of funds that are available, community-based organizations like Phoenix Health face considerable barriers in accessing these resources.

We are on the front lines of the addiction and recovery movement and we urgently need these funds to be able to do the work that we do.

Number two, the need for capital investment. There is a critical need for capital dollars and there's nothing in these dollars that prevents us from using it for capital.

And to improve our facilities and our services, each one of us, if we have a loved one that is

suffering with addiction, we should be able to send them to any of our organizations and not have to seek to go outside of the city. Investment in physical and operational infrastructure is essential to increase our capacity to serve those in need, particularly as we try to combat this crisis.

The fragmentation in services.

The current system faces significant fragmentation, particularly in supporting public hospitals and long-term treatment programs. We must address this and these dollars should be able to help us to seamlessly address this care for individuals that struggle with addiction. I am a former member of New York City Health + Hospital for 26 years and so our city hospitals are the safety net for our system, but our community-based organizations is what's going to sustain these individuals.

We've done very little to-- We've done some work to try to save people's lives, but we have done very little in helping them to recover and sustain their lives. The disparity in our communities, we know the statistics and it's been said already, I would just like to add one other neighborhood: Central Harlem. Out of OCME, that data is clear.

It is the Bronx, Central Harlem, and Staten Island. And our resources need to be targeted to those communities.

There's also a need for a public awareness campaign.

We've talked about it, the public is confused with the legalization of substances, with shops everywhere in our neighborhood. People don't know what to do, what's right, what the fentanyl crisis, does it actually affect our community? Is that someone else's illness? We need to have a comprehensive public service campaign to raise awareness and consciousness about the opioid crisis within the city. We should utilize our settlement funds for this purpose.

And there's also a lack of innovation in response to this crisis. We can't use the same old playbook. We have to be creative, we have to innovate.

One thing at Phoenix House, we sit on a lot of committees that deal with our law enforcement, working with our DEA and our partners at OCME. And law enforcement is very clear. We're not going to law enforcement our way out of this crisis.

When they remove what they call bad actors, someone else is there to replace. What's missing is the community-based organizations and partnerships that you see at this table here to go into these communities to be able to offer someone, not only just Narcan kits, that's a band-aid on the situation. It's the additional resources that are needed to help people find jobs, to work with them in terms of vocational, to tie them to primary care services, to help them enrich their lives.

Phoenix House takes pride in being able to provide what's called sober recreational activities. We provide acting classes on site. That is tied to their trauma and to be able to speak about it when you come into a treatment program.

Not only are you just going to counseling and individual services, but you're doing sober recreational. And so I invite any member of this committee and the council to come and visit us at Phoenix House, Talk to the individuals that are there in treatment and you can see where the money should be going. Thank you.

CHAIRPERSON LEE: Thank you. My team knows that I'm going to give them more work right now, but I

love going out for site visits because I think it's very different to see it versus read about it.

So, I would love to try and schedule something with you.

MS. FOSTER: Would love to have you. Thank you.

CHAIRPERSON LEE: And then one question I have for you really quickly is, can you just give me an example of what types of capital improvements you're talking about that would help on the programming side and to help you better serve the clients?

MS. FOSTER: Absolutely. And so while the one example I've given, it was in my testimony, is that the city believes in the clubhouse model. And Phoenix House was one of the organizations for the first time got into the clubhouse.

We have been-- It's been very difficult to find a location because there was no capital dollars associated with it. And if we're trying to engage people who struggle with mental health and they need a place to go, we know what real estate is like in New York City. Dollars should have been afforded to that.

Many of our organizations have not had any kind of upgrade where people are reluctant to go into

treatment. And so you're talking from anything as simple as boilers to windows to a new kitchen, to expanding a floor so that you'll be able to receive more people. In our city, we struggle with the number of beds for women.

We talk about women needing to access treatment. In our demographics, three quarters of our population are male, a quarter are female. That does not represent in terms of the number of them needing services, but they're not accessing treatment.

Why? Because I have to leave my child, right? I have to be separated from my family. There are not enough women and children programs in our city. Again, another priority population where we should be investing on dollars.

So, those are some of the infrastructure needs for our system. Our system cannot hold the patients that actually need the services. If we want to remove people from the subways, we want to take people off the street, where are they going?

CHAIRPERSON NARCISSE: Thank you. You've been a great partner, by the way. Thank you.

MS. FOSTER: Thank you.

CHAIRPERSON LEE: And Stephanie?

MS. MARQUESANO: Good afternoon, Chair Lee and Chair Narcisse and Councilmembers. Thank you so much for inviting me to testify today. My name is Stephanie Marquesano. I am Founder and President of an organization called The Harris Project. We focus specifically on prevention, treatment and systems transformation around co-occurring mental health and substance use disorders. I started The Harris Project in 2013 after the accidental overdose death of my son, Harris. He was 19 years old. Every residential treatment program said he had this thing called co-occurring disorders and they treated it. They never got to the mental health piece that would drive each and every recurrence in use.

I will say that I am a member of the New York State Opioid Settlement Fund Advisory Board where I was thrilled when attorney Letitia James ensured that the words co-occurring disorders were included six times in the language of the law.

The frustration for me on the board is that each and every time there is public opportunity for comment, I attend in the city, I attend up in Albany, members of the community consistently talk about mental health and trauma being drivers for use.

While we made an overarching theme co-occurring disorders, there is yet to be one single RFA that includes co-occurring disorders as far as dollars.

There's now a sheet that they blow into the RFA where you demonstrate your co-occurring capability, but without funds to support developing competency, it's really a futile effort.

On a more positive note, I co-chair the Westchester County Co-Occurring System of Care Committee. We are truly leading the nation on integrated services from prevention to treatment to systems transformation. Our jails are fully integrated. We work in peer certification that's fully integrated. We work with our unhoused population.

And so I'm here to say that success is possible. Dr. Lee, each and every time you talked about the siloed and fragmented systems, I thought we are making small steps. It is really, really challenging.

You asked about legislative opportunities. We know that three years ago, more than 1,200 individuals across the state of New York participated in 10 work groups where overwhelmingly they wanted a

single state agency that included OASIS and OMH, and that did not happen. They are now talking about a single license.

I am an attorney by training. Two agencies interpreting the same license will never get it the same way.

And so, I really encourage you all to consider strongly joining the movement. Westchester and the Mid-Hudson region are leading the way in integrated care. I'm doing work now with Nassau and Suffolk County. They are developing co-occurring system of care committees.

The commissioner in Westchester and I just presented to Monroe County. I've been in the Mohawk Valley, and I believe that the time is right for really making this happen. I want to give you some examples of concrete things that work that you can begin to think about today.

So, opioid response dollars being spent in Westchester County, there is $1 million committed to Prevention, Partnership to End Addiction, and the Harris Project, my organization, are working with our coalitions and Pace University to create a first-of-its-kind, three-session health curriculum, parents

and guardians in English and Spanish, school staff, faith leaders, community leaders. It's going really well. The pilot is amazing.

The feasibility study is moving forward. We're now partnering with BOCES to actually train health teachers, student assistance counselors.

What I will say is this, and it's not so popular: a lot of the traditional prevention programs are no longer racially and culturally competent.

They are now sticking SEL programs as an appendage to those. We have the first-of-its-kind integrated, evidence-based, hopefully, prevention curriculum. Evidence-based treatment, we are utilizing something called Encompass, single once-a-week integrated therapy for teens and young adults.

It is delivered in school and community settings. If you have school-based mental health satellites, and I've presented in Queens, actually, to one of the school districts, if you can deliver services in the least restrictive environment and keep your young people engaged, and if they can get to care because it's delivered right in their school, home run, co-occurring. 49.5% of our young people have a mental health challenge.

One in two people with a substance use issue also have a mental health challenge. 21 million people in this country have co-occurring disorders. Most have never heard of it.

Harm reduction: A lot of talk today about supplies. Supplies is not the only thing that goes with harm reduction. Access to non-abstinence-based treatment and care keeps people connected. While medication for opioid use disorder is key, SAMHSA will tell you it is part of an integrated plan. It is not a plan.

Just giving people medication alone without offering them access does not do it.

Wraparound supports: I'm going to say one of the saddest moments for me sitting here today as a family member who had a child who died was listening to the testimony about the supports that you give for families and loved ones who've had people who have died.

What are we doing to support the families to create possibilities for hope and recovery? We need to move away from mutual support groups, looking at things like community reinforcement and family training, invitation to change, shifting the

narrative from punitive blame and shame to opportunities where families and loved ones can support individuals who are struggling. Workforce development is a really key component of this.

These are not about trainings. These are about really investing in clinical consultations, supervision, support, and you look and you think, I mean, I'm a Brooklyn girl, and so I'm from Canarsie, and so for me, I know that this city may be big, but Westchester County, while we're small, is a very, very diverse county. Our programming, our availability of services go from Mount Vernon up to Bedford, from horse country to very urban, and so what I really want you to think is there's a lot of possibility.

You don't just have to stop the bleeding. This is money that is really designed not just to throw good money after bed. It's to really invest in innovation. So, thank you for the opportunity.

CHAIRPERSON NARCISSE: Thank you so much. I'm so proud of you for the work you're doing and coming from my district. I want to know: Have you stopped by for us to engage a little more?

MS. MARQUESANO: I would love, I mean, I come by with my family to visit Canarsie. My mother grew up in Coney Island, so I am-- You know, for me, it's very personal, but I will say this is-- It's really, really hard to know that there's a clear answer. I mean, we had a public service campaign that launched and it won 40 international awards, and most people haven't seen it. So, when we talk about campaigns, I say at the Opioid Settlement Board, this will be a win the day that there's not an Oasis campaign, an OMH campaign, and a DOH campaign.

These are the same people. Overdose, suicide, alcohol-related deaths, which nobody but the Surgeon General talk about anymore. The common root causes are-- We're going to keep whack-a-mole on the supply, but if you don't look at why demand is so high, you're not going to really get to the root causes.

They sat here today and said, 10 touch times before somebody felt like they trusted the individual. If we treat people with respect, if we look at this through a stages-of-change philosophy, if people are trained in motivational interviewing, and you're developing that therapeutic bond, and if they feel comfortable talking about all of their

things and not thinking you're going to send them somewhere else, that's how change happens.

CHAIRPERSON NARCISSE: Yeah, holistic approach. Thank you.

CHAIRPERSON LEE: Yeah, and I just wanted to echo, I hear you on all of those things, because as someone who started and ran an Article 31 clinic, it was very frustrating for me, because I can treat only one aspect, but you know that they're all interconnected and tied.

And I still remember back when I was working at a statewide health foundation back then, this was in 2007 or 2008, even at that time also the OMH and OASIS were thinking about merging, and we actually put a lot of dollars into that whole effort, which didn't end up going anywhere.

And I think it's frustrating, because a lot of it is based on insurance and what you can and cannot do, depending on which insurance and which agency you're going through. So, I hear you on that, and so we should definitely talk more about that.

MS. MARQUESANO: And even more challenging is that they are very excited, because the one place that they've integrated are crisis stabilization

centers. So, what it does is it keeps people out of the emergency rooms, however, there are 23 hour and 59 minute opportunities to recognize somebody has co-occurring disorders.

Now, if you don't have providers and community organizations to refer people to, the likelihood they're going to come right back in again, because their needs aren't being met. So, I'm like, this is one little piece, stop waving the flag and start telling us what you're going to do to do the next steps.

CHAIRPERSON LEE: Yup. Thank you.

MS. MARQUESANO: Thank you so much.

CHAIRPERSON LEE: Thank you. And of course, Gia Mitcham.

MS. MITCHAM: Hello and good afternoon, chairs and Councilmembers. Thank you for the opportunity to speak today. My name is Gia Mitchum. I am the New York Policy Associate at the Drug Policy Alliance. We are an advocacy organization working with grassroots groups and providers to address the harms of drug use and drug criminalization through health supports, social supports, and community well-being.

We thank the city for its investments in syringe service programs and for prioritizing harm reduction services in its spending of opioid settlement dollars. Syringe service programs are essential, especially for historically marginalized and over-policed communities, and provide much more than clean supplies and litter cleanup. Among the critical and community responsive services that SSPs provide are drop-in spaces, bathrooms and showers for unhoused community members.

A state comptroller report released this month highlights an alarming increase in homeless New York City residents, the number nearly doubling to 89,000 in the past two years. This means more of our neighbors with no access to shelter and no access to hygiene facilities.

In this time period, overdose death rates have continued to climb for black and Latino people who are also experiencing the highest rates of homelessness while overdose remains the leading cause of people, leading cause of death among people experiencing homelessness.

At drop-in spaces, people can access safe supplies, testing, behavioral support, health support and other forms of preventative care.

SSPs play a key role in providing low-threshold care and wraparound services, which help to address the harms caused by lack of housing, income, food and healthcare. Each service offered, whether it's a warm meal, a shower or a safe place to rest, is an immediate intervention and it's also a vital part of wellness and stability.

We need more of these services and spaces across the city. And in the Bronx, community members and elected officials in a number of neighborhoods are asking for more of them. By expanding access to drop-in services and strengthening the infrastructure of SSPs, we can create a stronger safety net for those left behind by traditional health and wellness systems.

We'll provide more details on these services and systems in our written testimony, but thank you.

CHAIRPERSON LEE: Thank you so much. I think that's all we have for testimony.

I'm just going to call a few names just to make sure that you're not here or have not been

recognized. Myrna Asia Betancourt, Joseph Conte, Valerie Reyes Jimenez, Nanette Brewster-Matthews, Erin Verrier, Jennifer Madera.

Is anyone here whose name I haven't called or on Zoom as well?

Okay.

CHAIRPERSON NARCISSE: Going once.

CHAIRPERSON LEE: Yes. Going once, going twice. Oh, wait, that's not it.

Oh, sorry. I have so many papers.

Okay, so I just want to thank all of you.

And I like having these almost the impromptu roundtables because it's really great to hear all of your feedback and what you all are seeing on the ground. So, I just want to thank you all for your testimonies today.

And that seeing that there is no one else here to testify, I'd like to note that written testimony, as I mentioned before, which will be reviewed in full by committee staff, and I'm telling you, they read every single word, may be submitted to the record up to 72 hours after the close of this hearing by emailing it to testimony@council.nyc.gov.

And, oh, no. Yes.

Thank you. Yes. Thank you. Yes, yes. No, thank you. Thank you, thank you, thank you so much for testifying with us today.

And I think that concludes our hearing. So, get home safe, everyone.

[GAVEL]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date January 31, 2025