CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

OF THE

THE COMMITTEE ON AGING, JOINTLY WITH THE COMMITTEE ON MENTAL HEALTH, DISABILITIES & ADDICTION
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Monday, June 9, 2025
Start: 1:20 P.M.
Recess: 4:00 P.M.

HELD AT: 250 Broadway - Committee Room, 16th Floor

B E F O R E: Hon. Crystal Hudson, Chair
Hon. Linda Lee, Chair

COUNCIL MEMBERS:

Shaun Abreu
Erik D. Bottcher
Tiffany Cabán
Shahana K. Hanif
Farah N. Louis
Kristy Marmorato
Darlene Mealy
Selvena N. Brooks-Powers
Jennifer Gutiérrez
Kristy Marmorato
Francisco P. Moya
Vickie Paladino
Carlina Rivera

OTHER COUNCIL MEMBERS ATTENDING: Krishnan

THE COMMITTEE ON AGING JOINTLY WITH THE COMMITTEE ON MENTAL HEALTH, DISABILITIES & ADDICTION

A P P E A R A N C E S

Ryan A. Murray,
Executive Deputy Commissioner and Chief Program Officer for the New York City Department for the Aging

Dr. H. Jean Wright II, PsyD, MDiv,
Executive Deputy Commissioner of the New York City Department of Health and Mental Hygiene (DOHMH)

Geordana Weber,
Chief Program Officer of Service Program for Older People (SPOP)

Anita Kwok,
Policy Analyst for United Neighborhood Houses (UNH)

Emma Bessire,
Senior Associate, Policy and Advocacy
Citymeals on Wheels

Navdeep Bains,
Associate Director of Advocacy & Policy at the Asian American Federation (AAF)

Chelsea Rose,
Policy and Advocacy Manager at Care For the Homeless (CFH)

Jeannine Cahill-Jackson,
Director of Elder Law Civil Practice
The Legal Aid Society

Christopher Leon Johnson,
Representing - Self

A P P E A R A N C E S (CONTINUED)

Kumarie Cruz,
Director of Bereavement + Education Services for The Samaritans of New York, Inc. (Suicide Prevention Center)

Fiodhna O'Grady,
Director of Government Relations for The Samaritans of New York, Inc. (Suicide Prevention Center)

Ronald Johnson,
Representing - Self

Saaif Alam,
Civic Leader from Jamaica Hills, Queens

SERGEANT AT HUANG: Sound check for the Committee on Mental Health, joint with the Committee on Aging. Today's date is June 9, 2025 — being recorded by Danny Huang on the 16th Floor Hearing Room.

(PAUSE)

SERGEANT AT ARMS: Good afternoon, and welcome to the New York City Council Hearing on Aging, joint with Mental Health, Disabilities, and Addiction.

At this time, to minimize disruptions, please place all electronic devices in vibrate or silent mode. Do not approach the dais at any time during this hearing.

If you would like to testify, please see one of the Sergeant at Arms. Thank you for your cooperation.

Chair, you may begin.

CHAIRPERSON HUDSON: [GAVEL] Good afternoon, everyone. I am Council Member Cystal Hudson, Chair of the Committee on Aging. My pronouns are she/her. Welcome to today's joint oversight hearing with the Committee on Mental Health, Disabilities, and Addiction on: *Mental Health & Older New Yorkers.*

Thank you to Chair Linda Lee for cohosting this important hearing.

We will also consider the following legislation...

SERGEANT AT ARMS: (INAUDIBLE)

CHAIRPERSON HUDSON: Okay, please hold, we have technical difficulties. No, problem.

(PAUSE)

CHAIRPERSON HUDSON: [GAVEL] Good afternoon, everyone. I am Council Member Cystal Hudson, Chair of the Committee on Aging. My pronouns are she/her. Welcome to today's joint oversight hearing with the Committee on Mental Health, Disabilities, and Addiction on: *Mental Health & Older New Yorkers*.

Thank you to Chair Linda Lee for cohosting this important hearing.

We will also consider the following legislation:

Introduction Number 1257, sponsored by me, requiring the cabinet for older New Yorkers to study and report on the provision of agency services to older adults with certain neurological and mental health conditions.

Proposed Resolution Number 106-A, also sponsored by me, calls on the New York State Legislature to pass, and the Governor to sign S.3563/A.2367, to expand eligibility for the Disability Rent Increase Exemption program to additional qualifying household members.

Resolution Number 736, sponsored by Council Member Tiffany Cabán, calls upon the New York State Legislature to introduce and pass, and the Governor to sign, legislation to increase funding for Assertive Community Treatment teams.

Resolution 852, sponsored by Council Member Shekar Krishnan, calls on the United States Congress and the President to take steps to protect Social Security.

Older New Yorkers currently account for 16.2% of the City’s population. And by 2040, NYC Aging projects that this will grow to 20.6%. That’s roughly 1.6 million people. As we strive to ensure that our city’s older adults age in place with dignity, addressing their mental health needs and properly supporting those living with neurological conditions must be a priority.

According to the Mayor's Office of Community Mental Health, older adults experience higher rates of late-onset mental health disorders, like anxiety and depression, as well as higher rates of neurological conditions, such as Parkinson's disease, mild cognitive impairment, and dementia. These conditions often present with atypical symptoms, making them more likely to be misdiagnosed or overlooked by providers who are not trained in geriatric care. For example, depression in older adults can manifest as fatigue, sleep disturbances, or physical complaints, symptoms that are often mistaken for normal aging or chronic physical illness. A shortage of geriatric providers in New York City exacerbates these issues.

Older adults also face unique barriers in accessing mental health care, including stigma and coexisting health conditions such as hearing or vision loss that complicate assessments.

Differentiating mental health symptoms from neurological conditions can be difficult, particularly among underserved and immigrant older adults who may be less likely to report mental health concerns. That is why routine and culturally

responsive mental health screenings in community and clinical settings are essential.

At today's hearing, we will assess how effectively the City is connecting older adults to these screenings and providing appropriate, accessible, and linguistically tailored services.

We will also examine NYC Aging's Geriatric Mental Health Initiative, a community based program designed to address older adults' mental health needs at older adult centers or OACs. Through this initiative, licensed mental health clinicians conduct screenings, provide counseling, and offer activities that raise awareness about mental health symptoms and available support.

I look forward to hearing from NYC Aging about how this program and related initiatives, like PROTEC (Providing Options to Elderly Clients Together) and Clinical Services, TelePROTECT, and Mental Health Support Services at NORCS, are working to reduce stigma, increase access, and connect older New Yorkers to treatment.

Today's oversight topic holds deep, personal significance for me. After nearly a decade serving as my mother's primary caregiver while she lived with

Alzheimer's disease, I began advocating for older adults, which ultimately led me to the City Council. I am proud of the work this committee and the Council have accomplished, together with advocates and providers, in championing the needs of older New Yorkers and tackling the City's mental health crisis with evidence-based solutions. My legislation, Introduction 1257, continues these efforts by requiring DOHMH to identify the 10 most common neurological conditions and the 10 most common mental health conditions affecting older New Yorkers.

Following this study, the Cabinet for Older New Yorkers would consider DOHMH's findings and recommended actions that city agencies will take to improve services for older adults living with the identified mental health and neurological conditions.

Our city agencies should set the example for how to holistically support our city's most vulnerable older adults, and my legislation would assist them in doing so.

I look forward to the Administration's feedback on this proposal as well as a broader discussion on how we can meet this moment to deliver

assistance for our rapidly aging city with growing mental health needs.

Finally, I want to highlight my resolution, Proposed Resolution Number 106-A, which calls on the State to expand eligibility for the Disability Rent Increase Exemption, or DRIE. DRIE helps eligible individuals living with disabilities remain in affordable housing by freezing their rent at the current level and exempting them from future rent increases. Unfortunately, state law sets extremely strict eligibility requirements for DRIE. To qualify, the individual living with a disability must be the Head of Household. This requirement excludes an estimated 7,400 households where a family member has a disability but is not the Head of Household. There is no good reason for this distinction. At a time when our city faces a massive housing crisis, the legislator must pass /A.2367, sponsored by Assemblymember Harvy Epstein, and S.3563, sponsored by Senator Cordell Cleare, to cut this red tape and help families stay in their homes.

Thank you to the Committee staff, Christopher Pepe, Chloë Rivera, and Saiyemul Hamid for their work on today's hearing. I would also like to thank my

staff, Andrew Wright, Elika Ruintan, and Omar Richardson.

I will now turn it over to Chair Lee for her opening remarks.

CHAIRPERSON LEE: Hi everyone, thank you for joining us today, uh, those who are here from our city agencies and partners, as well as advocates in the community, uh, and of course, thank you to my awesome co-chair for this hearing, Crystal Hudson

This is a topic that I'm really excited we're getting to do. I know that with you and your mom and your personal story, that's a really big driver of the work that you're doing in Aging -- and for me also, raised by my grandmother, I'm pretty sure she suffered from depression; although, she never got formally diagnosed, because there weren't a lot of places where she could go where she had the language accessibility for these services. Having also run KCS in the past, we had two senior centers, a Meals on Wheels program, a social adult day program, and then we also opened up an Article 31 Mental Health Clinic. Having done that work in the community, there are a lot of barriers and challenges we're seeing, especially with our immigrant New Yorkers in New York

City. We already know that stigma is a huge problem. We have a huge shortage of trained professionals, and it's very difficult to find the folks who can actually address and properly diagnose a lot of these things that we're seeing. And a lot of times in our communities, we would see people come in where they would say, "Oh, I'm feeling this pain in my arm or a pain in my leg," but really it was them physically manifesting their depression and anxiety, other mental health issues. And how do we also work with medical professionals to ensure that the training is in place and that they are aware of asking these questions in clinical settings? Because, as we all know, and I'm sure our partners know very well, we should treat the mental health aspect just as importantly as the physical aspect of someone's well-being. And this is something we hope to address with many of the hearing topics we're going to cover today. And of course, as we all know, I'm preaching to the choir here, but social isolation and loneliness, if not addressed, could manifest itself in other health risks and issues. And so we are trying to figure out how we can ensure routine mental health screenings both in the community and in

clinical settings. And we also need to invest, especially in the community groups that are providing these services. Really, it's our job on the Council definitely to ensure that this population, uh, older adults, receive the mental and physical health care that they deserve and that they continue to live in dignity in the community.

We look forward to hearing from the Administration today about the work you're doing. And thank you for being here, answering our questions, and for being our partners.

And just really quickly, he's not here... Okay, I'd like to read a statement, as we don't have a quorum. I'm going to read a statement from Council Member Cabán regarding her resolution, which we'll be hearing today. Let me take a moment to read it.

"Thank you, Chairs Lee and Hudson, and members of the Committee. Today, I'm proud to be discussing resolution 736, which calls upon the New York State Legislature to increase funding for assertive community treatment teams. ACT teams provide essential community-based care to individuals with serious mental illness by offering mobile services that include mental health and substance use

treatment, peer support, and vocational education. These teams help people who need mental health services to stay in their communities instead of being placed in more restrictive, costly hospital settings. Currently, ACT teams in the city are dealing with a growing demand for their services, with city officials testifying at budget hearings this spring that close to 700 people are waitlisted for these teams. At the same time, the need for them is increasingly urgent. ACT teams remain underfunded and unable to fully meet the demand. As a result, many individuals are left without the support they need. With more people requiring access to these services, it is now more important than ever that the Council takes the lead in advocating for greater funding to meet the growing need for ACT teams. In her State of the City Address earlier this year, Speaker Adams called for expanding access to these teams. This resolution is a call to action to ensure that our city and state provide effective community-based care, proven to reduce the burden on our overextended healthcare system. Expanding the funding for ACT teams will lead to better outcomes for individuals and our community as a whole, while also

reducing the need for more costly inpatient care. Thank you." And I wholeheartedly agree with Council Member Cabán's statement.

I also wanted to take a moment to thank my staff and the Committee staff for their work on this hearing. And I will now turn the mic back to Chair Hudson.

CHAIRPERSON HUDSON: Thank you so much, and I believe we might be joined by Council Member Krishnan a little bit later. So when he arrives, we'll allow him to deliver remarks as well.

Before we proceed, I'd like to acknowledge that we've been joined here by Council Members Louis, Schulman, Marmorato, Abreu, Cabán, and Bottcher.

I'll now turn it over to committee counsel to administer the oath to the representatives from the Administration.

COMMITTEE COUNSEL: Thank you, Chairs.

Good afternoon, if you could both please raise your right hand?

In accordance with the rules of the Council, I will administer the affirmation to the witnesses from the mayoral administration.

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 council members' questions?

ADMINISTRATION AFFIRMS

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Good afternoon, Chair Hudson, Chair Lee, Members of the Aging and Mental Health, Disabilities, and Addiction Committees. I am Ryan Murray, the Executive Deputy Commissioner of the New York City Department for the Aging. I appreciate the opportunity to testify before you today about mental health and older New Yorkers.

I would like to acknowledge that I'm joined by my colleague from the New York City Department of Health and Mental Hygiene, Dr. Jean Wright, the Executive Deputy Commissioner for Mental Hygiene, who will also be available to answer your questions.

New York City Aging provides mental health services in local communities by placing licensed mental health clinicians at older adult centers in all five boroughs. To our knowledge, our model is unique, and no other area agency on aging in the country provides mental health supports in a direct capacity. New York City's population is aging

rapidly. Today, nearly two million New Yorkers are aged 60 or older, and that number is expected to increase in the next decade. The Aging Committee has also acknowledged this fact and taken opportunities to highlight the City's growing needs for caregiver services, information sharing of resources, and, of course, mental health options for older adults.

As the population grows, so does the need to respond to mental health challenges, social isolation, and the complex web of services needed to help older adults age in place with dignity. Older adults are vulnerable to depression, anxiety, and cognitive decline, which can be exacerbated by isolation, financial insecurity, and limited access to culturally competent care.

To support older adults holistically, we developed the Geriatric Mental Health Initiative, DGMH, as a pilot program in 2016 and in its current contracted form since 2022, which offers access to older adults to licensed mental health clinicians at older adult centers twice a week, and our Hub and Spoke model that can provide help, engagement assessment, whenever an older adult may need it. These services are essential in helping older adults

address unmet mental health needs and to support maintaining their health, independence, and connection to their communities.

New York City's mental health programs are rooted in the Community Care Model, which you've heard us talk about many times, and the work of the Cabinet for Older New Yorkers, which this council has helped to codify. Fundamental to our efforts surrounding mental health and older adults is the Community Care Plan, which was developed in 2021, as part of a recognition of the growing and changing landscape of the older adult population. This also allowed New York City Aging to build on existing elements already in place to promote independence, self-reliance, and well-being for the aging population. Because mental health is an equal part of access to health care needs for older New Yorkers, those programs contributed to our vision. That is, the City that embraces longevity, addresses aging in a dignified and natural way, and helps older New Yorkers live vibrant lives. The DGMH program integrates mental health services into settings where older adults already go, such as OACs, as I've mentioned, or through partnerships with other city

programs already serving the aging population. To meet the growing need for mental health support for older adults, we currently operate at 88 collocated DGMH sites throughout the aging network, 11 of which are hub sites, all of which provide mental health services to older adults. The DGMH program and the hub-and-spoke model are one and the same, just two ways of reaching a greater number of older adults. In FY 2024, the DGMH program served nearly 5,900 older adults, with 850 accessing clinical services to support their mental health. We're on track to increase that number and serve more than 6,500 in FY 2025. There are still a couple of days to go, so I will update you on that at a later time. It is important to note that an older adult does not have to be a member of an older adult center to receive DGMH services, but can attend sessions or speak with counselors separate from the OAC programming. We continue to invest in strategies that reduce stigma, expand access, and improve coordination with our providers. We're working to ensure cultural competency in these services. Clinicians are bilingual and bicultural, meeting the needs of the community with the same requirements as our older

adult centers, too. When appropriate, groups are offered in other languages. We have done wellness programs in Cantonese. We had a bingo class, which was a wellness bingo. We've had a class in Polish, which was called, "Where do you Find a Good Pierogi?" And these are some of the ways we ensure that the sessions are engaging, reduce the stigma around talking about mental health, and bring people into conversations about issues they might be facing. These engagement sessions break down that stigma, as I said before, and they establish familiarity and trust with the clinician. Often, further discussions in a clinical setting come out of these sessions. Where there is stigma for individuals or communities surrounding mental health, which the Council spoke to a little earlier, we understand that we must take particular care to ensure that services are culturally appropriate and responsive to the context in which people live.

These efforts are essential to ensure mental health care is accessible, effective, and respectful of the diversity of New Yorkers. We want to help normalize access to care and provide support in environments that feel familiar and are welcoming

rather than just clinical. By coming into an OAC, an older adult will be able to access a hub of other services provided by the Department for the Aging and its partner network. If they don't want to come to an OAC, they can also schedule mental health counseling over the phone or by calling Aging Connect, who will then connect them to other programs. If older adults are not directly connected to one of our 88 DGMH made sites, OACs are further connected to clinicians throughout the hub-and-spoke model, where clinicians are leading group sessions -- which I mentioned before -- and they're able to partner to make sure that folks who are looking for supports are exposed to those services, and the people who are looking for services will follow the clinician back to their main site where individual live services are provided. Additionally, it is typical for OAC staff to include individuals with a social work background and formal training in social work in the social work field. NYC Aging also provides specific training for staff so that the information and assistance are relevant and that they're able to connect older adults to the range of programs and services, including addressing mental health needs. This allows NYC Aging to reach

an ever-growing number of older adults who are aging into our services, so that they can benefit from our programs.

In addition to formal mental health counseling, we offer a wide range of informal events and services to treat older adults holistically. Physical health is part of mental health for us, and the two are very intertwined. We celebrated National Older Adult Health and Fitness Day just two weeks ago, where we encouraged New Yorkers to stay active and engaged in their communities. In the past, we've hosted our Intergenerational Groove in Foley Square. I believe a few of you joined us for the Groove session last year. Thanks again for being there. This initiative brought over 1,000 older adults to a citywide dance event, promoting physical activity and well-being. We also hosted our *Healthy Aging Fair* in partnership with many regional hospitals and care providers, as well as the Department of Health and the Parks Department. Hundreds of older adults, even on a very rainy day, joined us for free screenings, wellness resources, and demonstrations. These efforts reflect our belief that aging includes movement, joy, and community. Ours is a holistic approach to mental

health, rooted in the understanding of community care, which recognizes that many factors are at work when addressing mental health and the broader needs of health for older adults.

While mental health needs are personal to an individual, their medical health care professionals, and their team, the community care role, as we are a social services agency, is really important in terms of establishing partnerships across the network and with practitioners. Food Insecurity, housing insecurity, social isolation, and financial insecurity are all compounding forces that can negatively impact the mental health of older adults. Considering that for many communities, there is stigma surrounding mental health, a large part of our effort is to ensure that older adults know where services are currently available. We're always open to increasing our efforts to improve marketing and outreach, aiming to reach a broader community. Additionally, we're ensuring that a wider range of services and programs is available for older adults. We must rely on our external or sister agency partners to ensure that the message is getting out well.

Mental health services must be embedded in this model, not treated separately. As we shared before, access to food, housing, transportation, legal assistance, case assistance, financial entitlements, and benefits should be prioritized and are as fundamental to addressing mental health as the clinical services. This is among the primary reasons why our home-delivered meals program, for example, which the co-chair mentioned earlier, is not just about delivering food; it is a lifeline for social connection, contact, and the ability to assess changes in a person's well-being. The daily interactions we have with the delivery staff are one of the few connections an older adult may have.

Additionally, our transportation program fills the critical need by helping older adults reach medical care, grocery stores, and other essential destinations. Our vision is a Community Care model where older adults can access comprehensive, connected services in the communities they helped build.

Following the creation of the Community Care Plan, it became clear that connections to services across various agency providers, nonprofits, and

other entities would require interagency collaboration, as demonstrated by the Cabinet for Older New Yorkers. Since its establishment in 2022, the many City agencies working together to break down silos and better coordinate services for older New Yorkers have focused on mental health supports as part of initiatives addressing mental health and identifying needs among older adults. New York City Health + Hospitals Corporation (H&H), the Department of Health and Mental Hygiene, the Mayor's Office of Community and Mental Health, the Mayor's Public Engagement Unit, and NYC Parks are all partner agencies that have collaborated with us to address unmet mental health issues. This has led to important initiatives, such as establishing a curriculum for frontline workers that raises awareness about existing community-based services for older New Yorkers. This ensures that whenever older adults enter any of these settings, whether it's at NYC Aging or beyond NYC Aging, those who see them, including clinicians and other professionals, understand the network and know how to connect individuals to services.

Additionally, the New York City Parks Geriatric Mental Health Program was developed as part of an initiative with the Cabinet. In fact, in that instance, because of the Cabinet for Older New Yorkers, we knew that older adults were not connected to NYC Aging programs, but were still receiving similar or adjacent services through another agency, the Department of Parks and Recreation. That enabled us to develop an initiative with NYC Parks to focus on mental health programming at their specialized Centers for Older Adults. We're truly meeting the needs of New Yorkers where they are, and not requiring them to come to our facilities. This is the direct work of the Body, and why the Cabinet for Older New Yorkers was formed. These collaborative efforts demonstrate how city government can operate more effectively and more compassionately through communication around shared goals.

I know part of this hearing is to discuss Introduction 1258, a bill which would require the Department of Health and Mental Hygiene to compile a list of common neurological and mental health conditions and then transmit those to the Cabinet for Older New Yorkers. As I've described to you, with our

efforts around the Parks Department, the role of the Cabinet for Older New Yorkers is to break down communication silos, develop outreach plans, and utilize existing resources to benefit older adults. We do not view the Cabinet as a think tank or a white paper cabinet designed to study items and issue reports. The initiative-driven model allows agencies to identify opportunities that meet goals and solve problems for older adults in real time. We are aligned with the Council on the need to address mental health concerns for older adults, as evidenced by the DGMH program and our efforts to advance understanding of brain health and cognitive aging research. Our concern will always be to remain true to the goals and the charge of the Cabinet for Older New Yorkers, and we look forward to discussing this bill further.

I continue to be proud of the great work that NYC Aging, our staff, and our provider network accomplish every day. We're working smarter, more efficiently, and more creatively to meet the growing needs of older adults in New York City. With your continued partnership, we can ensure that older New Yorkers are not only cared for but celebrated,

respected, and given every opportunity to thrive. Thank you.

CHAIRPERSON HUDSON: Thank you so much.

And before we move on to questions, I'd like to acknowledge that we've been joined by Council Members Zhuang and Krishnan. And Council Member Krishnan will give brief remarks about the resolution being considered today.

COUNCIL MEMBER KRISHNAN: Thank you.

Good afternoon, everyone, and thank you so much, Chairs Hudson and Lee.

I wanted to read a statement about my resolution that's being heard today on protecting Social Security.

I'm Council Member Shekar Krishnan, representing Jackson Heights and Elmhurst, Queens. Over the last 100 years, there has been no more powerful and treasured social program in the United States than Social Security. Sixty-nine million Americans rely on Social Security checks monthly, and over 16 million older adults are kept out of poverty thanks to this program. It is beyond belief that the Trump administration and Republicans in Congress have threatened to gut Social Security, a program popular

amongst the majority of Americans. Eighty-six percent of Republicans and 90% of Democrats support Social Security. Elon Musk's DOGE team has routinely made false claims and lobbied threats at the Social Security Administration, all to undermine confidence in the system. Now, as Elon Musk and Donald Trump publicly feuded about governing our country, and much more, the monthly payments that our city's older adults, individuals with disabilities, and families rely on to help pay their rent, electricity bills, and groceries are in jeopardy.

At every level of government, from the federal to the local level, we must realize that we cannot cut our way to prosperity. We must invest in the people and communities across this country. Standing up and protecting Social Security is a start. That's why I am proud that Resolution 852 is being heard in the Aging Committee today. This resolution calls on our partners in the federal government to do everything possible to protect Social Security from any cuts. This moment demands courage from all of us, and I can think of no worthier cause than standing up for our older adults,

our individuals with disabilities, and the many others who rely on Social Security.

I want to thank Chair Hudson for allowing this resolution to be heard at today's hearing, as well as Chair Lee. I want to thank my colleagues who have already signed on as co-sponsors. I look forward to moving this resolution forward to show that our city stands up to protect Social Security. Thank you

CHAIRPERSON HUDSON: Thank you so much, Council Member Krishnan. Couldn't agree with your statements, your resolution, and your sentiments more.

All right, we're going to jump into questions, starting with NYC Aging.

Can you share how many older adults received mental health services through DFTA-administered programs in Fiscal Year 2024?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Certainly, Chair, I'm going to focus on the geriatric mental health program in particular.

In fiscal year 2024, as I mentioned in my testimony, we saw around 5,900 individuals, specifically 5,891. That is a range of engagement, and some of the structured sessions I mentioned

earlier, which open up individuals to conversations about mental health issues. And that leads us to those who were assessed for more clinical services. I'm happy to speak about that. But over 5,900 individuals were served.

CHAIRPERSON HUDSON: Can you explain the delta there? I know 5,900 were served, 852 were accessing those clinical services...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Sure.

CHAIRPERSON HUDSON: you mentioned. And what does that look like? Are the 5,900 that were served just receiving basic information? And the others being referred themselves, are they coming in and asking for those types of services?

If you can get that...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Sure.

CHAIRPERSON HUDSON: that would be helpful.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: So, as I shared in testimony, one of the things that's really important for us is to ensure that conversations around mental health are routine, are normalized, and are accessible to older adults. In our structure, one of the things we do at our 88 sites is ensure that clinicians are on site at least

two days a week and facilitate conversations tailored to that particular community.

You've heard me talk about the "Where Do You Find a good pierogi?" as well as the bingo, not the game, but the game that was played to ensure you're looking at wellness. So, when we talk about the broader set, it refers to any of those sessions where we're engaging older adults on mental health issues.

As the Council acknowledged, and I shared, hopefully it would lead to individuals who, if they want more individualized time or are presenting something they want to talk with the clinician about, there would be an assessment that happens. And so what you're seeing as the delta is those who have moved forward from group sessions, and that structured session with a clinician, through to enrolling in individualized sessions with a clinician.

CHAIRPERSON HUDSON: Thank you so much for that.

Do you have numbers for the hub-and-spoke program, PROTECT, and clinical services for homebound older adults, TelePROTECT, Person-Centered, Trauma-

Informed Initiative, and reassurance and interpersonal supportive engagement by chance?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Sure. What I'll tell you is, again, I'm focused principally on the DGMH program, the clinical sessions that are provided there. I'll give you a number; over 10,883 actual sessions were delivered.

When we talk about the other...

CHAIRPERSON HUDSON: Sorry, 883 or 833?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: It’s 10,883.

CHAIRPERSON HUDSON: Thank you.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: And when you're referring to other programs that are embedded, there are two parts to this. We see a number of individuals outside of our OACs who might be in our Elder Justice Program, who we have clinicians on site as well, who are there if folks are survivors of abuse or crime, and there are services that are happening.

When discussing the PROTECT model, what we're doing is ensuring that — I'll come back to you with the numbers — it's a structured, evidence-based

program to help individuals make progress as survivors.

The other program that you mentioned, the Person-Centered, Trauma-Informed, is newer. We recently got a grant from JFNA (Jewish Federations of North America) to implement this program. And what we're looking at is, as you can imagine, trauma-informed care across the board; it's something that we need to deepen our practice around. And this is as a system, it's not just NYC Aging. So the PCTI is really -- we could get back to you on the number of individuals served. The primary focus of our discussion is enhancing our network's capacity to be more trauma-informed.

CHAIRPERSON HUDSON: Thank you.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: You're welcome.

CHAIRPERSON HUDSON: And do you have those numbers compared to Fiscal Year 2023 or pre-pandemic numbers?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Sure. Again, for our DGMH program, I have the information, but I don't currently have the pre-pandemic numbers

with me. However, as always, Council, you know I'll follow up, and we'll get you those numbers.

What I'm looking at across the board here is that in 2021, the numbers were 2,175 for all clients engaged as part of the program. And you see that number being about roughly consistent in 2022 with 2,017 Individuals. The number doubled in FY23, thereabouts, so it was 4,684. And as I shared in testimony, that number is going to jump again significantly in 2025. But I'll wait for the year to wrap up.

CHAIRPERSON HUDSON: Thank you so much.

What is the current case load or capacity per clinician in the DGMH Initiative?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I'll have to get back to you on that specific number. We don't have it on hand today.

CHAIRPERSON HUDSON: Okay, do you know offhand whether there are staffing shortages or waitlists?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: We don't have waitlists, but I -- And wouldn't frame it as a shortage. I think what we're always looking for, again, when I talked about the program, are culturally appropriate, bilingual/bicultural

individuals. Across the board in the clinical world, I think everyone will say that there are challenges in terms of recruiting and retaining individuals. So, whether it's licensed clinical social workers, licensed counselors, psychiatrists, and so on, it's expensive. And I think we have to do much more, as many of the reports — and the Health Department can speak to this separately — suggest we've got to invest more in the field as a whole.

So, what our model is built on is understanding that scarcity, if you will, with the resources that we have available. This is why the hub-and-spoke model is so important, where the clinician, based at an HQ, can move around to sites within the 88, ensuring a presence of a clinician. Again there's structured engagement, there's familiarity that happens with the clinician being on site. And then they're able to, you know, as people are interested, enroll individuals into individualized therapy, counseling sessions, and so on.

So there's a challenge in staffing overall, whether it involves mental health or social services. That is well documented, but our model, I think,

ensures that we can make services available on the ground. And I think we're always looking to recruit folks of various backgrounds so that we can maintain that cultural relevance to the community.

CHAIRPERSON HUDSON: Do you have a per-borough breakdown for those 88 locations?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I happen to have that right in front of me.

CHAIRPERSON HUDSON: Amazing!

EXECUTIVE DEPUTY COMMISSIONER MURRAY: One second. So, the Bronx has 15, Brooklyn has 26, Manhattan has 23, Queens has 19, and Staten Island has five.

CHAIRPERSON HUDSON: Thank you.

And then what geographic areas have limited or no access to DFTA-funded mental health services?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I would say that's not the case.

CHAIRPERSON HUDSON: Okay.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: But given the hub-and-spoke model, this is about making sure that clinical services are embedded in the community, just like our older adult centers. And it's why we emphasize having clinicians who move

around to various sites. Additionally, it's important to recognize that if you're in a center that's nearby, many of you have visited our centers, you know there's often another center nearby, not always, but often, you can go to the hub or another site nearby, call our Aging Connect number and get connected. So there isn't a particular community where we don't have services.

CHAIRPERSON HUDSON: Okay, good to hear.

Do all DFTA-funded older adult centers offer on-site mental health services?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: For the geriatric mental health program. They're at 88 sites.

CHAIRPERSON HUDSON: So, no?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: So, no, our older adult centers are at 33. However, given the model we've structured, there's an opportunity for older adult centers to partake in those services at a nearby center.

The other thing that we...

CHAIRPERSON HUDSON: So there's no plan explicitly to close those gaps?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I would echo what our Commissioner always says... (CROSS-TALK)

CHAIRPERSON HUDSON: You would say that there are no gaps... (CROSS-TALK)

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Well, I would say this, I would say that the needs are always going to outpace the resources available. And we are always looking at whether or not we need to expand. The program started out with 25 sites, it expanded to 45, and through the last RFP, we're now at 88.

So, there's a commitment on our part to have those conversations when we see a need to expand.

CHAIRPERSON HUDSON: Okay, great.

Therapy and counseling are more effective when they're consistent. How often can an older adult participate in a counseling session? And are there restrictions?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I would say that we would work with the clinicians to ensure that the assessment reflects whatever the plan needs to be. That's a pretty individualized treatment plan that would need to be put in place. I wouldn't necessarily say that there's a cap. I think it's all

about making sure that we're actually addressing the needs of the individuals. And just a fact, we, looking at our outcomes across a three-month period, see that there is an impact there. So I wouldn't necessarily talk about limits in this case, but rather that the assessment is as clear as possible so that we could address those needs.

CHAIRPERSON LEE: Can I ask a really quick follow-up? I know that for the clinics, they have to follow the state regulations, which require them to do at least three sessions to do an intake. So, is the (UNINTELLIGIBLE), I'm sorry...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Geriatric Mental Health, yeah...

CHAIRPERSON LEE: Geriatric Mental Health...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yeah, I'm not good with initialisms either.

CHAIRPERSON LEE: Yeah, sorry. Are they basically following that protocol (INAUDIBLE)...

(CROSS-TALK)

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Sure, the state guidelines are in place, and we are licensed by New York State. And at least one session — once you get into the services, at least once a

week — is usually part of the treatment plan. But again, it would be based on the plan for that individual.

CHAIRPERSON HUDSON: Okay, great.

I want to acknowledge that we've been joined by Council Member Banks.

How many OACs with on-site mental health services have Article 31 licensed mental health clinics versus other types of providers? Can you clarify the distinction in services between sites that have licensed Article 31 clinics and those that offer general mental health support or counseling?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Let me get back to you on the full answer to that. I'll follow up on this one.

CHAIRPERSON HUDSON: Okay.

Then I have several follow-ups. So I'll wait for you to come with your details.

Are DFTA-funded mental health services accessible to undocumented older adults or those without insurance?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yes.

CHAIRPERSON HUDSON: How are DFTA’s mental health programs integrating with NYC Health +

Hospitals, DOHMH, and Medicaid-funded behavioral health networks?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I think in short, one of the things that's important for us is, you know, and the Health Department can speak to the range of services offered for all, our goal is to ensure that older adults are, as I said before this will be like a repeated note, valuing, understanding that there are these services available, and making sure that they're available where they are. The clinicians who are working with older adults are then going to provide support. And they're aware that we spend a lot of time, whether it's via the Cabinet or, as you've heard me discuss before, Chair, the training that happens for the care teams at Health + Hospitals. We spend a lot of time coordinating and making sure that they're aware of what older adult centers are and vice versa. So referral networks are in place, whether it's a more specialized service that someone needs.

CHAIRPERSON HUDSON: Thank you for that.

And we did send the questions about Article 31 ahead of time in advance.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I have an answer for you.

CHAIRPERSON HUDSON: Okay, I'm ready.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: So, the breakdown is 68 are Article 31, and 20 are faculty practice model.

CHAIRPERSON HUDSON: Twenty?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Twenty... (CROSS-TALK)

CHAIRPERSON HUDSON: Are which model?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: The faculty practice model, which will...

CHAIRPERSON HUDSON: Faculty practice...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Which I can follow up with much more details on.

CHAIRPERSON HUDSON: Okay. Then let me just run down my list of questions with specific regard to Article 31.

Have there been any evaluations of the impact of Article 31 clinics within OACs on older adult mental health outcomes? For example, are there metrics such as improved depression scores, reduced hospitalizations, or increased service uptake that

demonstrate the effectiveness of these collocation models?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: So, yes, and we've done an evaluation. I'm not sure I'm distinguishing here between the types of facilities. But what we can tell you is that, uh, example in FY24, 27.2% of clients saw significant improvement in social isolation metrics over a three-month period. Similarly, when we look at loneliness, we saw a 28% improvement, uh, depression there's a 58% improvement for those who participate in the program, and then on anxiety 44%.

CHAIRPERSON HUDSON: Great. Given the diversity of New York City's older adult population, how do Article 31 clinics in OACs ensure that mental health services are linguistically and culturally appropriate? I know you mentioned a little bit of this earlier.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I mean, back to what we're looking for, right? We want to ensure that the individual is -- obviously, licensure is important, so that's a baseline. However, since the individuals are from the community, we need to deliver services in the languages accessible to the

particular community, as well as in the cultural context. Right? Given the stigma for everybody around mental health, there's a lot of work to be done in all communities. That's why it was is really important for us to be as engaging as possible, make sure that the clinicians aren't showing up on the day for therapy, but they're there as a consistent presence so that folks become familiar — that they're running workshops and group sessions where others can participate, that they're available for a walk-by conversation, where someone isn't being assessed — because that could be a barrier initially, but they're saying, I've been feeling this way or that way. So that presence is critically important. I also believe that the linguistic and cultural background of the clinicians is important. It's also, you know, we spent a lot of time, as we expanded, to make sure that those requirements are understood. We have some of our network providers here; at least one, SPOP (Service Program for Older People), is in the room, I believe. These are the things that we pay attention to in our oversight as well.

CHAIRPERSON HUDSON: Amazing. And I am going to make an assumption on your answers to my next

couple of questions, which is that bilingual clinicians or interpreters are readily available and that...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: There's always more to be done.

CHAIRPERSON HUDSON: Of course, of course, but they are available, generally speaking?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yes

CHAIRPERSON HUDSON: Right. And OACs and clinics coordinate outreach to immigrant and limited English proficiency communities to reduce stigma and increase engagement with mental health services, which is a little bit of what you just discussed.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: And just to tell you the languages that we have documented...

CHAIRPERSON HUDSON: Yeah...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: English, Spanish, Mandarin, Cantonese, Russian, Ukrainian, I told you Polish earlier, and Italian.

CHAIRPERSON HUDSON: Thank you.

How routinely do OAC staff and clinic staff communicate? Is there a formal coordination protocol or memorandum of understanding that guides

collaboration on participant needs, referrals, and programming?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Sure, just establishing where the older adult center -- The geriatric mental health program could be, is a coordination effort in of itself. Our team (INAUDIBLE) over here, and others, first are going to look at what – well, we look at, you know, we looked at TRIE neighborhoods before, Task for Racial Equity and Inclusion, and looked at all the data to ask where should we embed? Where are there no other Article 31 clinics in the community or other services, and where is an emerging need?

That's step one. With the OAC, we look at participation levels, and we've become a bit more flexible on that as the years have gone by. Because we want to ensure that, in our efforts, the outreach is there for where we establish a program. But as we said before, in our network, we have presentations, and if you're going to have the site there, you make sure that there's a private office that's available to the clinicians so that they can have one-on-one sessions, assessment, or clinical.

That's the kind of coordination that happens on the ground, facilitated between our oversight team at the Department for the Aging and the program officers at the older adult centers, as well as the clinicians, who are embedded and part of the calendar. I've gone to many, as you know, and I've seen over half the sites. And I show up on days where I don't know where the calendar is, and I meet a clinician who is there facilitating a group. And that's a sure sign that that coordination is strong. That's our expectation: that they're there, part of the center's workings, available, and reachable by the center directors.

And as we said before, not 100%, but often we have some in our staffing plans for older adult centers, folks with social work and other types of backgrounds, who may be speaking the same language and able to engage with each other.

CHAIRPERSON HUDSON: Thank you so much.

I want to acknowledge that we've also been joined by Council Members Hanif and Mealy.

To what extent do Article 31 clinics and OACs share client-level data or referrals while adhering to HIPAA and other privacy protections? Can OAC staff

refer participants directly to on-site clinical services?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yes.

CHAIRPERSON HUDSON: Okay.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: And yeah, so yes, there are referral pathways.

CHAIRPERSON HUDSON: Okay.

Are the Article 31 clinics involved in planning or co-hosting wellness programming within the OACs, such as mental health literacy workshops, grief groups, or stress reduction classes?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yes

CHAIRPERSON HUDSON: Yes?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Mm-hmm.

CHAIRPERSON HUDSON: Are mental health clinicians embedded in or visible at day-to-day center activities, or is their work separate from regular OAC activities?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yeah, as I shared, at least twice a week, just being present, but when you develop the calendar with, particularly the Geriatric and Mental Health Programs and the OACs, there's usually something happening that brings a conversation around mental health to

the table. Like, you may not call it that, given stigma and other barriers, but as we said, like "Summer Breeze Makes Me Feel Fine", is a workshop that was really about the weather and feelings that was recently hosted. Mental Health Awareness Month was last month in May. It's already June.

CHAIRPERSON HUDSON: Mm-hmm.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: And we, in our team at NYC Aging, did a fair amount of work to make sure that on the calendar, there were topics available in the Older adult centers. That is how we try to continue coordinating between the two programs.

CHAIRPERSON HUDSON: How do OACs and Article 31 clinics assess the changing mental health needs in their shared communities? And how do they adapt or scale programming based on observed trends and feedback?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Sure, I think even more to be done here. We just recently did an internal look at our oversight practices, and one of the things we did was survey nearly 200 older adult center directors, and you wouldn't be surprised, and Co-Chair Lee, having run these

programs, the center directors have said, "Look, I need additional training and support," around dealing with where their clients have cognitive decline and who've been members for 20-30 years. So, yes, training is an ongoing need for our program directors, and I think we've got much more to do here. But that's again why we spend time with our partners in the Cabinet and elsewhere.

CHAIRPERSON HUDSON: Thank you so much.

I'm going to kick it over to Chair Lee. I'll come back with some additional questions. Thank you.

CHAIRPERSON LEE: Okay, so I just wanted actually to follow up on some of the questions that were raised, some of which you did answer already.

In terms of the one that we just went over, in terms of the referrals, how fluid is it, so for example, if there are seniors from one senior center that need a clinician at a different one, like those referrals can happen — cross referrals — and it's not really an issue right?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yeah, no, that's the entire model for the hubs. Right? If there's a hub down the street and you are not a member there, that's okay. This is why we also

coordinate with our center directors. Those referrals can happen. And if there are folks who used to come to the center but now might now be homebound, for example, again, a referral can happen there from our case management program.

CHAIRPERSON LEE: And then, could you clarify for the hub-and-spoke program, you mentioned 10,883 sessions were provided. So, does that equal 10,883 unique individuals, or are those sessions unique sessions?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Unique sessions.

CHAIRPERSON LEE: Okay, unique sessions, okay.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: The individuals would be the 850.

CHAIRPERSON LEE: Got it. Okay, I just wanted to clarify.

Can you tell us more about the TelePROTECT program? And the reason I ask is that I wonder, when considering cost savings, if this could be something that -- but I just wanted to hear more about the TelePROTECT program.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yeah, as I as I shared earlier, I think it's important to

ensure that telehealth/telemedicine is available across the board. The TelePROTECT and PROTECT programs are particularly unique in terms of their focus. So I wouldn't want to distract from the broader message here, which is that our services across the board are embedded in our older adult centers in our communities and available to anyone who needs them.

With that model, I think we've shifted a little bit to looking at and, you know, we just had an RFP for this, looking at any other models that are out there.

CHAIRPERSON LEE: Mm-hmm.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Because what's important is the capacity of our network, and this is the frontline workers. So, telehealth beyond TelePROTECT, I think, is important and also available. And I think we can spend more time looking at those models.

CHAIRPERSON LEE: I agree. And some of them, especially for the homebound, maybe can benefit from that as well, which would be great.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Absolutely.

CHAIRPERSON LEE: I still remember when we were at the beginning of COVID, we had staff literally going to individual homes of our seniors to help them download Zoom and all these other things so that they could access services. Which was a huge feat in and of itself. I'm not going to lie. That was a lot of work on our staff , you know, to sort of combat that isolation and depression feeling, which definitely helped.

And can you clarify? I know you mentioned that year-over-year, there has been an increase in the number of on-site mental health clinics. And so, is there going to be another RFP, or is it open where you could just sort of add folks if they're interested in having one at their site?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Well, I think our team is always looking for opportunities to expand. So one example of a recent expansion that's going to happen is actually not in an OAC, but I might have mentioned it very briefly in testimony, but with the Parks Department, where they have rec centers that are “senior rec centers”, and they call them senior rec centers, and they're not our older adult centers. And it was important, given the

location, this is one of -- there are two, one in Fort Hamilton, the other one in the Greenbelt, that we recently expanded to, where we're going to have a program there with the Parks Department. So we always look at the opportunities to expand, I think, when you're talking about a significant expansion, then that might get into the world of additional resources needed.

CHAIRPERSON LEE: Okay. Actually, that was -- thank you, because that was actually one of the questions I had written when I was following -- because I love the idea of partnering with the Parks Department, especially because there are so many groups that do a lot of activities in the park — older adult groups, they do a lot of the tai chichi, they do different games that they have in the Parks Department.

So speaking on that, maybe this isn't totally fleshed out yet, because it might be a new partnership you're talking about, but how do you plan on partnering with the specific groups that are within the Parks Department? Because I know it's in a park, but some of the groups may not be affiliated with the New York City Aging Department. And so, how

do we get them into the mix, and then also capture the data on that? Or is it something more informal?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: No, I think we're going formal. But we start informal, so that's part of the Cabinet. And the goal for us, we see over 250,000 older adults across our network, depending on -- the service is unique. Right? However, there are nearly two million older adults, and whether they're seen at a Department of Health clinic, H&H Hospital, or elsewhere, such as the Parks Department, they're getting benefits through the Department of Social Services. Our goal is to continuously expand our reach and focus on older adults. So when you think about the Cabinet, it is important for us to always have these conversations. So, in the development of that initiative, it was the Parks Department Liaison. — We have a liaison structure with our Cabinet where we meet monthly, and then the principles — the commissioners, deputy mayors, and others — meet on a quarterly basis to keep track of what's going on. But on a monthly basis, we have breakout groups. There's an Aging Health Committee, for example, and this is where the magic actually happens. So when you say, look at a

particular issue, I say, of course we will. It's not a report, then; it's really about us thinking about what the things are that we could do first at no cost to either agency or any of the agencies involved. It's using existing resources, and this happened to be one, the older adults who are over there, our clinical services are nearby, let's get them over to you. That's how that happened. And then there are some more formal agreements that are put in place to then share data, and so on. So we'll be happy to come back at some point and report on how that initiative went.

CHAIRPERSON LEE: I feel like we're doing a good tag team, because you're totally reminding me of the questions that I want to ask. You're teeing me up for -- I had a question around the Cabinet, actually, because I'm a huge fan of finding alternative programs. Because I'm a firm believer that not everything has to be clinically based per se, I think there's a lot of power in peer support groups as well. And, so, is the Cabinet discussing alternative programs that could be beneficial for older adults experiencing mental health issues? And then, in terms of other partners, is there an effort with reaching

out to the faith-based communities? Because I know that in my community, in the Korean community, there's a lot of churches that are essentially senior centers. And I feel like we need to somehow bring them into the mix. Is there also outreach in that community for the faith-based groups?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yeah. And as you all know, there are many senior centers in churches.

CHAIRPERSON LEE: Yes.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Which I've visited -- in the basements. So yes, and yes, we are having some of those conversations. We could have more and then get more structured around it. Right, I think it is good to go where people are and strengthen those partnerships. That's the baseline for everything we're doing.

To your point about peer support, I'm talking a lot, but I might turn to my colleague or keep going, obviously, peer models work. We know that, right? They're not appropriate for everything. It's critical for individualized sessions to occur, and sometimes peer models happen in groups where clinicians are present, and then someone says, "Well,

you know, who knows that older adult?" And that has happened. Here are some other things you can think about. Here's what this means for my life." So as much as we could engage and as appropriately as we could engage peers and others, I think, of course, we're committed to that.

CHAIRPERSON LEE: Thank you.

Then, switching over more to Dr. Wright — given the growing mental health needs of the aging population — and also given the workforce shortage, are you guys partnering with, let's say CUNY for example, or other local graduate schools and medical schools to sort of help build the pipeline and train more folks to go into the field?

DR. WRIGHT: Thank you for your question, Council Member.

We do not officially partner with CUNY in terms of training or dedicated pipelines to train providers, but we do work with those individuals and those agencies to make sure that if there is a need, we're available to them.

CHAIRPERSON LEE: Okay.

And then, if there are any opportunities for trainings with different agencies, for example, how

closely do you partner with DFTA? In case there are trainings that we need to provide, not just for the clinical staff, but also for the non-clinical staff at the senior centers?

DR. WRIGHT: Yeah, we partner with NYC Aging quite a bit, and also because we're both members of the Mayor's Office, that's where that partnership really takes place as well. But, you know, we're open to more partnerships and any suggestions that are out there.

CHAIRPERSON LEE: Okay. And then, in terms of data, I love it because I think it tells a story, not the whole picture, but it tells a snapshot of a story. So, even though DOHMH does not directly operate services, the data collected guides policy and funding decisions, for sure. So, how is DOHMH ensuring that mental health data related to older adults is actively shared and used by other city agencies? I mean, I know obviously we don't want to violate HIPAA, but I do think that there's an opportunity to use whatever data is being collected and have that shared so that it could better inform how we deliver services. So...

DR. WRIGHT: Absolutely, Chair. What I can tell you is that all of our data is posted on our website. So that's easily accessible there as well. But we also share it with our providers and the partnerships that we have in the community. You may remember that in 2019, we had a deep dive on the Report For Aging; we don't do that every year, but every year we produce surveillance data and epidemiological data, and that's collected and posted every year. So it may not be as deep of a dive as the report in 2019, but certainly, we are constantly publishing data and making it available on the website.

CHAIRPERSON LEE: Okay, and then do you -- but can there be a partnership where there is data collected at the OACs that are part of the Geriatric Mental Health Initiative that then gets forwarded to DOHM, can it go that way as well?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I think data sharing across agencies depends on the level of data you're thinking about, but strengthening our communication and coordination is at the core of what we're trying to do always. So,

depending on what you're thinking about, the answer could be yes.

While you're discussing data, you know, the Bold Coalition that we've joined, which focuses on Alzheimer's and related dementias, as well as other related disorders, is led by the Department of Health. I understand that they've been examining surveillance and prevalence data, among other things.

CHAIRPERSON LEE: Mm-hmm.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: And just wrapped up a needs assessment as one example. So, whether it's programmatic data sharing of things we're seeing, I think that's easy to do. Other kinds of coordination, such as referrals, depending on whether it's a behavioral site or something else, are more structured. But, the Department of Health is leading a coalition focused on the Bold Coalition, which Dr. Wright could talk about a little bit more...

CHAIRPERSON LEE: Mm-hmm.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: We're members, and we're looking forward to what comes out of that.

DR. WRIGHT: And I would just add, Chair, that we partnered with NYC Aging on other things like vaccines, and sharing that data, health updates, new resources, funding opportunities like RFPs, requests for proposals. So when NYC Aging asks us to participate and partner, we certainly say yes.

CHAIRPERSON LEE: Mm-hmm.

What gaps do you think exist in the current surveillance systems, I guess, when it comes to understanding older adult mental health in New York City? And what investments do you think are needed to close those gaps?

DR. WRIGHT: I think one thing that we could say is that continued communication amongst our agencies that are already partnering together and making sure that the data we have is accurate and up to date, it's a challenge sometimes. Because, like the most recent data we have in terms of surveillance you mentioned is 2022. So getting that real-time data, I think, is a challenge. Not sure about my colleague, but that's a major challenge.

CHAIRPERSON LEE: Okay, so I would say maybe one of the gaps is just having up-to-date information.

Okay, the Mayor's Office – So, OCMH, the 2024 annual report highlights loneliness and social isolation among older adults as major mental health risks. What does this tell us about the scope and trajectory of these issues among this population, especially post-COVID Covid?

DR. WRIGHT: Thank you for your question, Chair.

I think the important thing is that when we look at overall mental health in New Yorkers, older adults aged 65 and older actually had better mental health outcomes than the other age groups. That being said, you hit on an excellent point, and that is that social isolation is a challenge for all New Yorkers in terms of dealing with mental health, especially since the pandemic. But we are also looking at serious psychological distress, unmet need for mental health treatment. All of those areas, older adults are actually fairing better than the rest of New Yorkers. So, again, it's important, and when you consider things like clubhouses and some of our programs that particularly cater to older adults, it actually addresses social isolation head-on. As our colleague talked about earlier, peers and having

individuals that form a community actually reduce that social isolation.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: And Chair, the things I will add is, you know, there are some prevalence estimates, as you've seen probably in the report that you referred to just now, Ava Wong and team published, about 20% of the population meet the criteria for mental health issues. And that is expected to increase significantly in the next few years. It's interesting, DOHMH's report opens up with, "Uncertainty, isolation, and loss are things that exacerbated mental health issues and the experiences for all older New Yorkers." We'll say that again, right? "Uncertainty, isolation, and loss," which for older adults could be a thing, especially as one ages. So we know it is going to be critical for all of us to ensure that we're squarely looking at mental health. And I will pull back again to say, and that includes all of the things, whether it's folks say social determinants over here, I say community care over here, we're all talking about the things that drive folks to not to feel well. And how do we keep those conditions at a level, whether it's food, housing, and otherwise, where you know the

stressors, if you will, are less? Then, when cognitive decline can occur with age, you're also ensuring that you have strong connections to your clinical care. Right? Your healthcare practitioner, just like we are now used to saying you should go to your routine visit once a year, and that's become something that everybody appreciates, then mental health should be normalized as well, getting that mental health checkup.

CHAIRPERSON LEE: Definitely. And especially given the population, I know depression rates are pretty high.

According to the 2019 DOHMH report on Health of Older Adults, I think the report said about 9% of New Yorkers aged 65 and older screened positive for depression. I would imagine it's gone up quite a bit. And rates were higher among women and Latino older adults compared to white older adults. And older adults in lower-income households were far more likely to experience depression than those in higher-income households.

So, can you speak to whether those rates have changed since the pandemic, and if so, how? And how does DOHMH currently monitor and track trends in

depression and older adults, and how frequently is the data updated?

DR. WRIGHT: Thank you for the question, Chair.

I'll answer the back end of the question first. We are doing surveillance on all New Yorkers, including older adults, on a regular basis. That's why I said, even though we haven't had a more recent report since 2019, it's updated every year.

In terms of the specifics about the pandemic, what we saw in 2021 was that about 67% of adults in New York reported feeling socially isolated in that year. That was reduced by 40% by 2023. So the trend is getting better...

CHAIRPERSON LEE: Okay.

DR. WRIGHT: in terms of that specific question that you asked. Specifically, for older adults, only 28% reported feeling socially isolated, which is the lowest percentage among all the groups we report on. So, again, although that is still a concern, it is less than the number for the rest of New Yorkers, based on that particular data. In terms of depression, anxiety, as you alluded to, those are certainly some challenges that all New Yorkers are

dealing with. And it's actually, again, for the 65 and older group, it's actually less than the rest of New Yorkers. So the outcomes are better for older New Yorkers 65 and above.

CHAIRPERSON LEE: Hmm. Okay, and can you point us to where we can find the data online? The most recent one, I'm sorry.

DR. WRIGHT: Yes, so you should be able to get that from our website.

UNKNOWN: The Epi Data Briefs.

DR. WRIGHT: Oh, the Epi Data Briefs, I'm sorry.

CHAIRPERSON LEE: Okay.

DR. WRIGHT: Thank you. Epi Data Briefs.

CHAIRPERSON LEE: Got it. Okay, perfect.

Then similarly, the same question with dementia and cognitive decline and co-occurring mental health conditions, how have those rates -- Do you know what the most recent numbers or how those rates have changed since COVID in 2019?

DR. WRIGHT: Right. So, from a national aspect, let me just give you that first and then compare it. So an estimated 6.7 million older adults with dementia, in this particular case, Alzheimer's

disease, Alzheimer's dementia is the most common type of dementia, accounting for 60 to 80% in the United States.

As Chair Hudson mentioned earlier, and I appreciate your opening statement, Chair. I also have a personal stake in it, my mom, who will be 90 in October, is diagnosed with vascular dementia. So not only am I a clinician who deals with geriatric psychology, although that's not my area of expertise, but my siblings, being caregivers, and my sister having the brunt of that now that we all live out of town, really is looking at how that information can be used to support caregivers. And so, when you think about the particular data you mentioned, Chair, for New Yorkers, it is actually not as prevalent as the rest of the country. So it's a little less than the national average, but it's still prevalent.

CHAIRPERSON LEE: Is that because people are not getting tested and diagnosed?

CHAIRPERSON HUDSON: (INAUDIBLE) What’s the reason?

CHAIRPERSON LEE: Yeah, what's the reason?

DR. WRIGHT: I think it's, you know, I can't give you a clinical answer, but I can give you a more

anecdotal answer if that's okay. And that is one thing, as an example, my mom is in Ohio, rural Ohio, not as many opportunities to be in communion, social Isolation is higher. New York, being dense, actually has better outcomes for adults in terms of older adults in that way, in that there is more accessibility to more peers in terms of that. But in terms of whether they're getting tested and whether there is a specific test that some are getting and not getting, I really can't speak to that, Chair.

CHAIRPERSON LEE: Yeah, because I know you have to go through a neurological process, which I think is more cumbersome, I would say. So I could see how that could potentially deter people from going through that process, especially if there is not a doctor or physician who they feel understands their cultural and language needs, maybe.

CHAIRPERSON HUDSON: Well, yeah...

DR. WRIGHT: And we have a unit that’s, you know, in Check Well, which is our center for Health and Equity, and I am just looking at some of the – they don’t have specific numbers for testing or how many people get tested, so that is why I am kind of

hesitating on giving you a definitive answer. We don't have a definitive answer on testing.

CHAIRPERSON HUDSON: I do know that, uh, if you are Black or Hispanic, your rate, or at least Alzheimer's disease, is more prevalent in those communities, and also for women.

CHAIRPERSON LEE: Yeah.

CHAIRPERSON HUDSON: So...

CHAIRPERSON LEE: Yes...

CHAIRPERSON HUDSON: I don't know population-wise compared to the rest of the county, where New York stands, but...

CHAIRPERSON LEE: Yeah.

CHAIRPERSON HUDSON: I am surprised to hear that statistic.

CHAIRPERSON LEE: Me, too, especially on the depression and the suicide, also. Because I know that studies have shown that a lot of older Asian adult women have some of the highest rates of suicide and depression, so, I am just wondering if that's being -- - I mean, it may just be -- I don't know in terms of number-wise, but maybe percentage population comparatively, but...

DR. WRIGHT: Yeah...

CHAIRPERSON LEE: Interesting...

DR. WRIGHT: And, Chair Hudson hit on an important point, and that is the inequities based on race or ethnicity. So certainly the numbers are a lot worse for that particular group — Black and Latino New Yorkers — it is definitely more pervasive.

CHAIRPERSON LEE: And when you are collecting the data, is it mostly from -- where is it coming from? Is it mostly just hospitals, individual physician offices, uh, nonprofit organizations? Like, where is the data being collected from?

DR. WRIGHT: The data is being collected from the areas that we support. We have over 200 providers with whom we also partner, including Health + Hospitals, and we also partner with our CBOs. So, it would be a combination of all those accessible points that have data on the folks that we can connect with in New York.

CHAIRPERSON LEE: Okay, good to know.

Just quickly, this is more for DOHMH, but also hopefully DFTA. Have you partnered with the state folks as well on the mental health piece?

DR. WRIGHT: Yes, we do partner with the State. The State actually has a little more robust

budget, as you can imagine, in that regard. But we certainly partner with them on many of our programs.

CHAIRPERSON LEE: Okay, the reason why I am saying that is because maybe you guys can join me, I am, like, really, really, really trying to plead with the State Department of Health, specifically their Medicaid department, because -- and I think the OMH Commissioner, Ann Sullivan, is really great, too, on this, and she gets it. Because we are trying to see -- it's not just about, like, how do we sustain the services that are happening in the city with a lot of our providers in the nonprofit community? So, how do we not only reimburse higher for these current services, but also cast the net wider to secure more reimbursement for things like education and outreach services? Because I would argue that those are just as important. So, I don't know; maybe you guys can join me in that advocacy, because I would love to see it become both wider and deeper in terms of what we can do. Because that is more of a State issue, I understand. It's not really something that the City can change, but I would love to see if there is more we could do there and partner on.

DR. WRIGHT: We appreciate your support in that regard, Chair.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: We are happy to partner as well. We know that there is some shifting landscape at the play right now. While we were granted the authority for the 1115 Waiver, the Department of Social Services and others are taking the lead there. We agree with Community Care and all the other factors that affect it, but I think we are going to -- we are happy to partner, but also know that there is some shifting sand right now.

CHAIRPERSON LEE: Yeah. Okay, I will toss it back to you.

CHAIRPERSON HUDSON: Before I continue with my questions, I want to turn it over to Council Member Mealy.

COUNCIL MEMBER MEALY: Good afternoon, I just have a few questions regarding Community Care. If we have the programs in the centers, what would your clinician consider someone mentally, and refer them for the services? If someone comes into the senior center with 10 bags and an umbrella, how would the clinician approach that senior to even try to get

them some resources that they need? Could you give me examples?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Sure. So I don't want to go too far down with this case, because... (CROSS-TALK)

COUNCIL MEMBER MEALY: That's a rabbit hole, we don't want to...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I am not assessing the individual, I am not their clinical provider...

COUNCIL MEMBER MEALY: Not...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: The first thing I would say, though, you know, again, you have been to many of our centers, Council Member, and I can think of three or four where I have met someone with their bags and umbrellas and so on, including in the last two months, what... (CROSS-TALK)

COUNCIL MEMBER MEALY: (INAUDIBLE)

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I'll give you that example where the staff, so put clinicians aside, although the center director was a licensed clinical social worker herself, she wasn't part of the DGMH program, but they did have a DGMH program at that site also. First and foremost, some

compassion and engagement, not making assumptions about what's going on with all the bags and the umbrellas. Right? We have to ensure that we remain welcoming to everybody and try to understand what's going on with that individual. It so happened that the center director knew that individual really well, and there were things at play. The person was in care, and they were in psychiatric care, and that day, and many days, not all days, they were engaged (TIMER) as much as possible with their other center participants. Right? So, engagement involves trying to engage a person compassionately and understand what's going on. This is independent of the DGMH program. It is something we expect of all centers. Then I think, given that that person was in care, if there was a need for ongoing counseling or other kinds of engagement, then I think the center director would be working closely with the DGMH clinician onsite to... (CROSS-TALK)

COUNCIL MEMBER MEALY: How often do you think they come together and talk about those kinds of issues with our seniors? That they will still be treated with dignity. And how you can delicately make sure that their resources are given to them in a

proper manner, respectfully. How often do you think that each center talks about how they would address situations like that?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I can't give you a number on this record. What I will tell you is... (CROSS-TALK)

COUNCIL MEMBER MEALY: Do you think we should? Because it’s happening.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Let me answer the first part of the question, Council Member... (CROSS-TALK)

COUNCIL MEMBER MEALY: (INAUDIBLE) seniors are displaced, and that’s gotten them mentally unstable just as well.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Sure.

COUNCIL MEMBER MEALY: Some are homeless.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yes.

COUNCIL MEMBER MEALY: So, how can we get a group that addresses those issues right there with the clinician?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yeah, so, again, Council Member, part of what I was trying to respond to in your questioning was specifically about the center director, period, and the staffing

onsite. Right? I am sure the Chair of Health, having run centers, understands case conferencing and making sure you know your members is a bottom line. As I shared earlier in a response to a question from, I think, Chair Hudson, we at NYC Aging have been looking at our assessment process, and actually, one of the things that came up when we surveyed our Older Adult Center directors was precisely what you are talking about. So while they might be dealing very carefully with that on a site-by-site basis, there is more to be done here. There are some programs that are great at engaging, I think of, I don't want to name names, but there are some programs that might have more individuals who are homeless or unhoused than others, and are spending a lot of time sharing best practices within the network. But, to your question about how often, I think they are required to have these conversations about their members, you know, frequently... (CROSS-TALK)

COUNCIL MEMBER MEALY: They are having conversations, but...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yes...

COUNCIL MEMBER MEALY: what are they really trying to hone in on to make sure that our seniors are... (CROSS-TALK)

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Case assessment -- let me be concrete with you, then. Case assistance and making sure that the individuals are connected... (CROSS-TALK)

COUNCIL MEMBER MEALY: Do you have any database on the cases?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I – yes, of course I do. I... (CROSS-TALK)

COUNCIL MEMBER MEALY: I would like to see that.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I am happy to provide you with numbers around case assistance. I am also happy to invite you to conversations where you have providers who are more apt at this. One of the things we plan to do, as we shared earlier, is provide updated training for all our older adult centers.

COUNCIL MEMBER MEALY: I love it. I will definitely meet with you.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Okay.

COUNCIL MEMBER MEALY: Can I have one extra question?

You said the RFP. How soon would you feel an RFP will be given? I read in one of the statements -- how long is the process for RFPs for a program?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Are you referring to the RFP process for the DGMH program or generally?

COUNCIL MEMBER MEALY: Generally, and both really.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Well, you previously chaired the Contracts Committee...

COUNCIL MEMBER MEALY: Mm-hmm.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: So, you know that a request for a proposal process could be rapid, or it could take some time. Now, in terms of DGMH, we are in the middle of our programs right now, so there isn't an RFP planned for tomorrow. As an example... (CROSS-TALK)

COUNCIL MEMBER MEALY: What about a senior center?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: If you are asking about the older adult centers, the answer is still the same. From Budget, as well as prior,

which is we were looking at whether or not we should release an RFP this year. You have heard that message before.

COUNCIL MEMBER MEALY: Well, the Commissioner said that it would be happening.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I think in our -- you can refer to her testimony in the last hearing, she also said that we are going to -- that is our plan, we are going to have to look carefully, especially with the current context, federal government, and otherwise, at whether or not it is prudent to release the RFP right now, i.e., the end of this year. Our plan remains that we will continue planning as if so...

COUNCIL MEMBER MEALY: Okay.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: But we are going to be looking at whether or not the release timeline is prudent. And I think she said that in different words...

COUNCIL MEMBER MEALY: Okay.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: at the last hearing.

COUNCIL MEMBER MEALY: I was just trying to make sure I am hearing everything correctly.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: It is consistent messaging.

COUNCIL MEMBER MEALY: But, please know that, uh, right now we need an RFP in Brooklyn with Mount Ararat. Right now, it is on the City's dime. So, I am looking forward to making sure that a senior center, a senior house, and 420 units need a certified RFP center. So please keep that in mind — Mount Ararat.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Okay, thank you for that. You have raised Mount Ararat many times. I am glad that... (CROSS-TALK)

COUNCIL MEMBER MEALY: (INAUDIBLE)

EXECUTIVE DEPUTY COMMISSIONER MURRAY: (INAUDIBLE) Fort Greene is in there with you...

COUNCIL MEMBER MEALY: Yeah...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: And operating that center currently. And thank you for the funding to make that happen.

COUNCIL MEMBER MEALY: Thank you, I would love to talk to you afterwards.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Okay.

COUNCIL MEMBER MEALY: Thank you.

CHAIRPERSON HUDSON: Thank you, Council Member.

Okay, how many DFTA clinicians or partner providers speak a language other than English? I know we talked extensively about the presence of the services, but do we have a number?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I can get back to you on that number...

CHAIRPERSON HUDSON: Great. And the languages that you mentioned before are the languages that you provide services in, but are those also the same as the languages that are most in demand? And I guess a better question would be, is there a gap between the languages that you're providing services in and other languages that are being requested at sites?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Sure, I think we'd have to look at that really carefully. But these are the in demand languages across our network. There are obviously emerging languages.

CHAIRPERSON HUDSON: We're good.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: But I would have to get back to you on whether or not there's gaps. But this is a pretty broad swath of languages for New York.

CHAIRPERSON HUDSON: Yeah, definitely. And I would just be curious to know, and you can follow up

with this if you don't have it now, but at those 88 sites, how many people? Is it, you know, one per every three or four, or like across those different languages? You know? Those are the types of numbers I would like to know.

What strategies are in place to address stigma around mental health services among older New Yorkers, among immigrant communities specifically, and communities of color? We've all sort of touched on this a little bit, but I'm wondering if there's sort of deliberate programming or information being provided, approaches being taken to address the stigma?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I think, as I shared earlier, the way the program is structured itself is in response to stigma in terms of structured unstructured engagements, presence of a clinician, ensuring that the clinicians of the community have the background, have the language capacity. That in itself ensures that the presence, and this is a routine, you know, Judy, who comes here every Tuesday and Thursday, that is deliberate. It might not seem so to you, but it might sound like just a thing; however, it's deliberate so that the

clinician becomes a part of the Older Adult Center. That is what the model is based on.

CHAIRPERSON HUDSON: That's great. It doesn't sound like just a little thing, I just want to make sure I'm getting the information on the record.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Okay.

CHAIRPERSON HUDSON: I think it's a great example that that is exactly how we lift the stigma and how somebody would then feel like it's no big deal to see Judy or talk to Judy, because Judy's always there. So I'm with you.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: And, Chair, I mean, the other thing is, I know we're saying better off outcomes, I love that, we'll keep looking at prevalence data. The reality is that we know that folks are either late-onset of mental health, underdiagnosed, misdiagnosed, and untreated. Those are all facts that could be reflected in prevalence data or other places. We will soon be sharing with you a little more about the Needs Assessment Survey from last summer and comparing that to other reports that are out there. Some things that struck me, you know, 53% in from whichever report I was reading the other day, and I'll find you the

source, older adults who don't actually seek support. That in itself sets up this conversation for making sure that we're where people are. And then part two, folks are only going to loved ones. Accessing other care networks and resources is automatically a place where we're likely to encounter some challenges. So, this is why, thank you, Doc, for sharing your personal story earlier. It's so important that we spend time with caregivers. You've heard the Commissioner talk about caregiving before, and all of us, right, like, today, it is actually the birthday of one of my aunts, who passed away recently, and had a rapid cognitive decline in her last few months with us. So, preparing caregivers and the caregivers -- and the caregiver in her life was my other aunt, who's a bonus mom, and she's 80, well, I don't know if she wants me telling her age, but I'll do it anyway, she's 80 -- she's 83, and her sister was 86. And so it's really important, as we talk about mental health and who and where we are, it's not just in our centers, it's making sure that we're everywhere, especially for caregivers. And I don't need to preach. I don't need to tell you that, but it's

really important for everyone here. That is a place where we need to go, also to reduce stigma.

CHAIRPERSON HUDSON: Absolutely. And since we're on the topic, and Council Member Mealy brought this up as well, I do want just to ask, one of the fastest growing populations is homeless older adults, and so I'm wondering, too, if there's -- because I'd imagine there has to be some sort of overlap perhaps with mental health diagnoses and people who might be newly experiencing homelessness. So, I'm just wondering if there are specific efforts to address that in some of the clinics, in some of these older adult centers, how people are being connected to resources and services in that way, too? From a preventive perspective.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: You go first.

DR. WRIGHT: Yeah, I'll start, and you can jump in. So, I think it's important what you're saying in terms of several things. One is the stigma. And so having workshops and focus groups is one area that, when we talk about the disparities, as an example, so we've had over 54 workshops and over six focus groups for those 50 years old and older, for

Black participants specifically — in terms of how they understand the information that is being given out there. And so some of the information we've received in terms of key insights, current communications, are we communicating in a way that a person can actually receive the information? Think about it, if it's just on the website, that's going to exclude some folks, right? If it's just being handed out in a pamphlet, that's going to exclude some folks. So we really need to understand how people receive information. So that's the kind of feedback that you get when you have focus groups. I think also looking at stigma, denial, and shame, and looking at the lack of awareness are key barriers. But you also have to understand who's having the conversation? Are they credible messengers, for example? You know, we talked about peers earlier, so that's very, very important. When you think about where individuals are going to get this information, they are going to some of these mental health clinics. Chair Lee's favorite clubhouses, right?

CHAIRPERSON LEE: Mm-hmm.

DR. WRIGHT: A lot of the individuals are 55 and older, but they have serious mental illness.

Fifty-five percent of the folks who are in our supportive housing are seniors.

CHAIRPERSON HUDSON: Mm-hmm.

DR. WRIGHT: And so that's a resource in terms of how to get connected. When you think about all those things, it's a multi-pronged approach in terms of how we communicate. How do we get the information to individuals? What are the things we're hearing and that we can implement immediately? And then how do we meet people where they are, so that -- we can't just talk about stigma, we also have to talk about inclusion.

CHAIRPERSON HUDSON: Mm-hmm.

DR. WRIGHT: And I think you can't have one conversation without the other.

CHAIRPERSON HUDSON: Thank you

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Covered it.

The other thing I would say is that, frankly, our provider network is critically important here. We don't just have older adult center operators. These are nonprofits that are embedded in the community and offer multi-service often, or have really strong ties. I'm already thinking about folks at Encore,

Project Find, others that run supportive housing, uh, operators who also have Older adult centers. It's important to make sure that we continue to support the nonprofits in this case, who are there and are the front lines of responding to all these needs. You know, the Department of Social Services isn't here today, but we spent a lot of time making sure that, whether it is with their supportive housing or adult protective services and others, they're at the front lines of this in terms of outreach. Folks who have aged in place on the streets are known to the community providers conducting outreach, and they have moved people more quickly into supportive housing in the past few years. So spot on. More to be done.

CHAIRPERSON HUDSON: That's good to know, thank you.

Are DFTA's mental health programs reaching LGBTQIA+ older New Yorkers? And do you have any data on those aging alone or disconnected from traditional family support?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: We could follow up on that specifically in terms of data, but yes, we are reaching LGBT community

members, and we have programs that are run by LGBT community organizations, as well, thinking about SAGE as one example. It has both an older adult center and caregivers. They are not operating a DGMH program, but our operators will work closely with many of the program providers. So, yes, is the short answer for data because it's an intricate question. I'll be happy to follow up.

CHAIRPERSON HUDSON: Okay, sounds good, thank you.

How have the Fiscal Year -- I am going to go into budget and contracts for a second, okay?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Okay.

CHAIRPERSON HUDSON: Or for a few minutes, rather.

How have the Fiscal Year 2024 and 2025 PEGS impacted funding for DFTA’s mental health services, particularly for staff, contracts, and outreach initiatives?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: They haven’t.

CHAIRPERSON HUDSON: Okay. At all?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: No.

CHAIRPERSON HUDSON: Okay. How long did it take to implement the most recent RFP for expanded DGMH services?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Do you mean how long it took to develop the RFP itself?

CHAIRPERSON HUDSON: No, to award it?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: What I will say is, yeah, I try to give the spirit of the question, the pilot was 2016, as we shared before, and we have expanded the program twice. And the expansion that was -- so if you are doing the math from 2016 to 2022, that's one timeline. But, in terms of the RFP development process, I am happy to come back to you with the actual timeline from when it was released to when the provider was selected, to when they started. If you want to talk about concrete procurement timelines...

CHAIRPERSON HUDSON: Yeah.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I'm happy to figure that out.

CHAIRPERSON HUDSON: Okay, that would be great, thank you.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: It kind of gets a little bit to Council Member Mealy's kind of question — how long does it take to do an RFP?

CHAIRPERSON HUDSON: Yeah.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Right?

CHAIRPERSON HUDSON: What additional investments are needed to scale services like (INAUDIBLE) and TelePROTECT to meet the demand of homebound older adults?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I think I hinted at this earlier, telehealth itself is the thing that we need to spend time on. Right? And it is available today in our programs in terms of folks who might be homebound. And there is much more that we can do there. I think there have been a number of models in the world, PROTECT being one, and we are actively trying to look at what emerging models are best suited, and how we increase our capacity. I think, while there are many specialist organizations out there right now, some are here, some are probably watching at home. One thing that is important to the Commissioner and me is making sure that we are deepening our bench. And you were asking questions earlier, Council Member, about the folks in centers.

Right? It is so important that, even if there are no clinicians in centers, peers, or otherwise, the people who are operating have that capacity to engage compassionately, know where the resources are — that's why we spent the time training. So, there, I would say what is important is actual training. It is actually deepening the models in documenting. That is what is important for those models.

CHAIRPERSON HUDSON: Thank you. And what is the plan for sustaining DOJ or OMH-funded mental health pilot programs when grant funding ends?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Well, like with most, we will -- the world of grants is different, Chair. (LAUGHS)

CHAIRPERSON HUDSON: And that's why...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: And, you know, we...

CHAIRPERSON HUDSON: And that's why I'm asking the question.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I know. Look, I think we're pleased with new developments like, you know, the JFNA funding. That's a foundation. So we are continuing to, our development team, with our program team, look for opportunities

out there where we can shift what we're doing. And, thank you for the reminder.

You know, we have a new program called Boost, which again we're looking for other models, that will be supporting older adults, whether it's telehealth or Survivors of Violence and Abuse, we continue to do development work on our side. Where we can integrate clients with the existing core DGMH programs, we're also doing that.

CHAIRPERSON HUDSON: Thank you

How does DFTA evaluate the effectiveness of its mental health programs?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I shared some stats with you before. In terms of you know, looking three months after the initial clinical sessions begin, and as you heard from 20% to 60%, thereabouts, improvements in various metrics. That's the kind of research that we're doing -- impact research that we're doing internally.

CHAIRPERSON HUDSON: Great.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: You should also know that we are, you know, we recently had a pitch fest that we participated in, which was like looking for research partners. So, thank you to

-- if any of you are here, there are like eight researchers who are interested in partnering with us to evaluate some of the impact of our programs. And one of them is on the impact of older adult center programming on the cognitive well-being of older adults. Not just mental health programs, but all programs. And the other one is implementing STEAM, like science, technology, engineering, and math, uh, arts and math programming. So we are actively -- I know we responded to some of the university partnerships, but we're actively looking to deepen what we know, understand, and are able to do. And older adults in community are asking for it as well.

CHAIRPERSON HUDSON: Thank you.

Do you collect client feedback for each of your mental health initiatives?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I'm seeing a nod here that says not for each. But I can tell you some of the -- probably get back to you with some of...

CHAIRPERSON HUDSON: The nod I saw was a no, but...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yeah, that’s not... (CROSS-TALK)

CHAIRPERSON HUDSON: (LAUGHS) But, go ahead and tell me...

EXECUTIVE DEPUTY COMMISSIONER MURRAY: (LAUGHS) INAUDIBLE) not for each...

CHAIRPERSON HUDSON: (LAUGHS) Okay, okay.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I knew what that meant. (LAUGHS) We do get feedback.

CHAIRPERSON HUDSON: That’s agency speak over there.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: Yeah, yeah, (LAUGHS). Not for... I'm responding to your question, not for each. Based on that, I think on how that's structured with the clinician and so on, but we are evaluating the programs. And in some of our areas -- so we didn't spend much time talking about our elder justice programs. We are often surveying and getting feedback from clients, as they, you know, have benefited from our services. So, not for each program, for a variety of reasons, but that is our practice and our goal.

CHAIRPERSON HUDSON: Okay, thank you.

And what are the three greatest unmet mental health needs of older New Yorkers, according to providers?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: That is -- You want me to rank right now, huh? Here's what I will say: I will join Dr. Wright in acknowledging that we need to invest in staff continuously. That's documented well throughout. Build those partnerships from social work schools and other settings to ensure that we have capacity within our networks to provide services and pay folks well. Right? That's part of what we need to do. In terms of mental health needs, I think the stigma piece, again, is well documented; folks are not thinking, "Let me go to get my mental health checkup." Maybe folks are going to the dentist twice, not once. Absolutely, folks are going for their annual checkups. So, I think routinizing mental health care and wellness is also a major top three.

CHAIRPERSON HUDSON: Yeah.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I think the third is screening. Once we get past the "this is a part of it," like, really, "What do I do when and if I feel, or if the doctor, or if the clinician tells me?" (sic) And I think that's why the DGMH program continues to be important. Because it provides on-site, in community access and navigation support in to individuals so that they can get care.

CHAIRPERSON HUDSON: Thank you.

I want to ask a couple of questions about my bill, which would require the Cabinet for Older New Yorkers to study and report on the provision of agency services to older adults with certain neurological and mental health conditions.

Does the City currently track older adults with neurological or mental health conditions across city agencies?

(PAUSE)

CHAIRPERSON HUDSON: So, if HRA, if somebody is interfacing with HRA, as an example, and somebody in HRA somewhere is like, "You know what? This person might have Alzheimer's disease." Are they then sharing, at least, we've had 10 people that have come through our agency with DOHMH to say, or even NYC Aging, to say, "Hey, just FYI." "Or maybe you want to know." "Or maybe you have programs or services, or resources that might be relevant to this person, whom we've already interacted with."

DR. WRIGHT: So, Chair, I can't speak to that level of detail in terms of the communication between agencies, but I can certainly find out what communication is occurring.

In terms of tracking neurological data, we do have our Unit of Health Equity that I mentioned earlier, which mainly focuses on dementias specifically. So, it's a fairly new unit, and I can certainly get back to you in any detail in that regard.

But in terms of internal cross-system amongst other city agencies, I can't speak to that today.

CHAIRPERSON HUDSON: Mm-hmm. Yeah, and that's fair. I think generally we could probably all agree that there isn't enough inter-agency discussion, coordination, or collaboration. And this is probably across all government entities, not just here in New York City. So, just, you know, I want to note that for all of us.

How would DOHMH work to identify the top 10 neurological and mental health conditions affecting older adults? And what might the anticipated timeline for something like that be?

DR. WRIGHT: I can't speak to the timeline, but what I would say is the way we gather other Information is through EPI Briefs and surveys, community surveys. Also, talking to our providers would be a way to gather that information.

Do not have a specific timeline that I can give you today.

CHAIRPERSON HUDSON: Okay. And what criteria would DOHMH use to determine the most common conditions, for example, incidence prevalence, impact on service use, or another metric?

(PAUSE)

DR. WRIGHT: Repeat the question, I'm sorry, Chair.

CHAIRPERSON HUDSON: What criteria would DOHMH use to determine the most common conditions, for example, incidence, like rate of incidents, prevalence, the impact on service use, or perhaps another metric?

DR. WRIGHT: Understood. Again, by using the EPI Data Briefs and the surveillance that we do, we would be able to rank them in that regard.

CHAIRPERSON HUDSON: Okay.

One other just sort of anecdotal piece that I'd like to offer is, you know, in my office, we've been contacted by a number of constituents who have neighbors, they're calling essentially on behalf of their neighbors. And usually, this is the story: I have a neighbor, Miss Jones, she's lived next door to

me or across the street from me for the last 20-30 years. She's now, you know, in the hallways late at night or outside. She's ringing my bell late at night. She's making these claims that don't seem to make sense, you know, things like that. Or maybe she's walking down the street in her night gown, which I've never seen her do before. For me, because I have personal experience with Alzheimer's disease and the early stages, and how it can present, you know, I usually think well, maybe this person has some form of dementia. We've also had cases where the police department has been involved in folks making these sorts of very elaborate claims about their neighbors, and come to find out when you do a little bit more digging, they do have dementia, but because they are socially isolated, they may not have any next of kin, and because their neighbors, and even the NYPD, may not be familial with these types of symptoms. Then, you know, they are obviously not really getting the type of help they need. I mean, we've gone to doctors' appointments with people before just because they have nobody to sort of advocate or even confirm or get the information, so

that we can then help them get access to the types of resources that they may be qualified for.

So I just wanted to share that, because I think there are so many opportunities for us to be doing a lot more in terms of how we are supporting every, you know, New Yorker who might be experiencing something like this, who does not have the support systems, who may not be going to older adult centers or drop-in clinics, or anything like that. So, just thinking about how we can get the word out. How do we share information? I have legislation trying to make the NYPD get training on how to spot Alzheimer's and dementia and things like that. But, you know, I don't know if you have any thoughts or anything to share. But it would be really great for us to all sort of think together collaboratively about how we -- especially with the growing older adult population -- and assuming that these types of diseases might become more prevalent, how do we actually address some of the folks with these?

DR. WRIGHT: So first and foremost, first thank you for that sharing. I would start with 988. So we need to do much, much, more in terms of — when I say us, as a collective -- as a city...

CHAIRPERSON HUDSON: Mm-hmm.

DR. WRIGHT: to make sure that people understand that 988 could be for someone who just needs someone to talk to, all the way to, you know, having some major challenges, all the way to being suicidal. The continuum is that great. So the vast majority could be helped by calling 988. There is going to be a clinician readily available to talk to them on the phone, and if necessary, a mobile team, a crisis mobile team, will be deployed. And that team will assess the individual, and they would be the experts, clinically, to find out what we are really dealing with. Your average neighbor probably doesn't know that, as you have just pointed out. So if you're not sure about 911 or 988, call 988 and let us assist you in that way. That is probably the time to call the police, because you're not paying attention to...

CHAIRPERSON HUDSON: Right.

DR. WRIGHT: any public safety issue...

CHAIRPERSON HUDSON: Right.

DR. WRIGHT: Nine times out of 10, people who make calls are calling about something they've observed — a person, family member, as you put it, and a neighbor. They're not usually calling about

themselves necessarily, so that's another reason that if you are observing something, you should call 988 first. Then let those professionals take it from there, and then get you connected to whatever is needed. They know what to do.

CHAIRPERSON HUDSON: Thank you for that.

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I think it is also important to go back to why the Cabinet exists, which is to strengthen information sharing at all access points. So, 988, absolutely. Some folks are going to continue to call 911, and the precinct is going to show up, and that is why it was important for us to establish a liaison, an older adult liaison, in every precinct. So, now I can say that nearly 40,000 members of the service and civilians have been trained; however, posters are needed. And this is always going to be more that needs to be done here. And I think maybe we could consider looking at what a partnership would look like to zero in on some of these issues that are showing in community. We literally had a call a couple of weeks ago, this kind of exact call, where we got the person who oversees all of the older adult liaisons on the phone, they got the liaison to go down with some people from the

precinct, and APS got involved, because there was a hoarding situation and a few other things going on. And that person got a pathway to care, but they have received multiple calls up until that point; they just happened to finally get to the right structure. So, we need to strengthen our access points, whether it's the hospitals or the police department, or anywhere else, so that we are all speaking the same language. And said it earlier, around geriatrics, we need to make sure to deepen that practice. So, I think we could spend more time evolving the training that everyone has taken, so that they are better positioned to act.

CHAIRPERSON HUDSON: Thank you.

I am going to throw it back over to Chair Lee for some additional questions. Thank you.

CHAIRPERSON LEE: Just one last bucket around the substance use and opioids. The reports have shown that substance use, especially among those 65 and older, has increased in recent years. Can you just speak to whether those rates have changed since the pandemic, and if so, how?

DR. WRIGHT: Thank you for your question, Chair Lee. Before I answer that question, let me give

you the answer to the question you had asked earlier about depression. So, it did increase slightly from the 9% that was quoted earlier.

CHAIRPERSON LEE: Okay.

DR. WRIGHT: But it's at 12% for older adults, which is still slightly lower than the rest of New Yorkers... (CROSS-TALK)

CHAIRPERSON LEE: Yeah, okay.

DR. WRIGHT: which was 13%. So, you were correct, it was slightly elevated, but only at 12% compared to 9% — and compared to the rest of New York, which was 13%.

CHAIRPERSON LEE: Okay.

DR. WRIGHT: In terms of your question specific to overdose, so as you probably remember from our previous hearing, although the rates of overdose have declined very slightly for all of New York, for Black and brown New Yorkers, it has increased.

CHAIRPERSON LEE: Mmm!

DR. WRIGHT: So, in specific geographic areas, we're talking in terms of the Bronx, in East Harlem and other areas, that I'm blanking on right now, but in terms of the comparison to previous, uh, you said

the pandemic, yes, they have increased quite a bit. So, that is a major concern for us at the Health Department, so we certainly are taking that information very seriously and working with our partners across the city to make sure that, one, we address those exactly in the vulnerable communities where it exists, but also talking to our community providers to make sure that we have an understanding of what are we doing to address those issues. So, we're taking it very seriously.

CHAIRPERSON LEE: Okay, perfect.

Given the rise in substance-related mortality among older New Yorkers, does DOHMH differentiate and report on substance misuse patterns, like using prescription opioids versus illicit opioids for the older adult population?

DR. WRIGHT: We do...

CHAIRPERSON LEE: Okay.

DR. WRIGHT: And that's part of the surveillance data that is gathered and published.

CHAIRPERSON LEE: Okay. Mm-hmm?

CHAIRPERSON HUDSON: Just, and maybe this is more anecdotal from your perspective, and there isn't any clear data, but I'm just curious to know, are the

older adults who are engaged in substance use, are they because they're people who are aging that have been using, or are we seeing a more prevalence of older adults who are maybe new users?

DR. WRIGHT: If I'm understanding your question correctly, I would say I cannot speak to whether they are new users or not. What I can say is that we are tracking the type of substance, and generally, individuals have a history of substance use for a period of time.

CHAIRPERSON HUDSON: Okay, thank you.

DR. WRIGHT: Mm-hmm.

CHAIRPERSON LEE: And just lastly, does DOHMH work with or consult with citywide harm reduction programs to ensure integration of age-appropriate screenings and referrals for older adults who suffer from addiction?

DR. WRIGHT: We do.

CHAIRPERSON LEE: Okay. So, groups like On Point and others? So you coordinate with them?

DR. WRIGHT: Absolutely.

CHAIRPERSON LEE: Okay, perfect, thank you.

CHAIRPERSON HUDSON: Okay, sorry, and I just had one last question about the legislation. If the

Cabinet for Older New Yorkers is not the ideal forum for developing the report required by Intro 1257, as you state in your testimony, Executive Deputy Commissioner, how would you ensure, through this legislation, that all relevant agencies weigh in on how to improve the provision of services to older adults with neurological and mental health conditions?

EXECUTIVE DEPUTY COMMISSIONER MURRAY: I would say that is part -- thinking of the Cabinet as action-oriented and looking at sustainability, I would imagine that what we would do here is, with the Health Department, H&H, Office of Community Mental Health, and others who are always active in the Cabinet, we prioritize these conversations, as I mentioned earlier, you know, the agencies are the ones who do the work. So the Cabinet itself doesn't just issue reports. Like, we have our needs assessment data that's coming out, and through the Bold Coalition, there is work that's going to be done as a part of strategic planning. So those are already reports that should be available. I would think that through the Cabinet, one of the things that we commit to, as we always do, is thinking about the

initiatives that go into this. Like what we would actually do, whether it's, I don't know, we talked about training for a little bit just now and making sure that all frontline staff -- so we already have one of those initiatives, but maybe there's a focus in terms of content, a new module, something in person, some commissioners rounds, maybe, uh, bring some experts to the table. I think that's the kind of thing that the Cabinet does, and that we'd be more than happy to advance.

CHAIRPERSON HUDSON: Thank you so much.

Thank you both for your testimonies and for answering all of our questions. I'm going to move on to public testimony. So, thank you, we appreciate your time. Okay.

(PAUSE)

CHAIRPERSON HUDSON: All right, I now open the hearing for public testimony. I want to remind members of the public that this is a formal 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 with the Sergeant at Arms and wait to be recognized. When recognized, you will have two minutes to speak on the oversight topic: *Mental Health & Older New Yorkers,* or Introduction 1257, Proposed Resolution 106-A, Resolution 736, or Resolution 852.

If you have a written statement or additional testimony you wish to submit for the record, please provide a copy of that testimony to the Sergeant at Arms.

You may also email written testimony to testimony@council.nyc.gov within 72 hours after the close of this hearing. Audio and video recordings will not be accepted.

And I will start momentarily with panel one, Geordana Weber, thank you, Kumarie Cruz, Fiodhna O'Grady, and Anita Kwok.

GEORDANA WEBER: Good afternoon. I am Geordana Weber, Chief Program Officer of Service Program for Older People (SPOP). Thank you, Chairs Hudson and Lee, for holding this oversight hearing on the subject of Mental Health and Older New Yorkers. I am grateful for this opportunity to address the two committees today.

SPOP plays a unique role in supporting the health, emotional well-being, and independence of older adults – and has done so for more than 45 years. We are the only agency in the city that is exclusively dedicated to community-based mental health care for older adults. We provide outpatient treatment to over 1,000 people each year through individual and group therapy, assessments, medication management, and psychiatric rehabilitation.

We understand that older adults may face multiple barriers to mental healthcare, and we have developed strategic partnerships with older adult centers, hospitals, and other community-based

organizations that connect us to those who might otherwise have no access.

We have also built a network of 20 service locations and satellites, seven of which are DGMH sites in Manhattan, Brooklyn, and the Bronx, where clients can receive mental healthcare at the same place they receive aging support services.

Chair Hudson, to an earlier question, SPOP also has three LGBT-specific sites.

We were especially proud when NYC Aging adopted SPOP's co-location treatment model to integrate mental healthcare into older adult centers.

Education is central to our mission, and we share our expertise with other organizations and professionals who work with older adults. We teach the ins and outs of Medicare billing, which ultimately expands the provider pool. In other cases, we provide workforce training on such topics as older adult substance use, trauma, or suicidality.

And, Chair Lee, regarding one of your earlier questions, SPOP is also in year two of a social work career pathway, bringing MSW interns into the older adult mental health orbit.

Perhaps our most important role (TIMER), however, is advocating on behalf of older adults with mental health needs. Our goal is to increase access to treatment throughout the city, and we believe that older New Yorkers deserve to have the entire city on their side. While we love what we do, we can't be the only ones doing it.

I am here today to express SPOP's enthusiastic support for Introduction Number 1257, which focuses on the identification of the leading neurological and mental health conditions affecting older adults. We believe that this bill will call attention to healthcare needs and impact decisions affecting policy and service delivery options. Clear data can inform a strategy to address those healthcare needs.

Through our work, we have seen the despair that ensues when a person's needs increase as their financial resources dwindle, which only exacerbates their mental health or neurological condition. This bill recognizes the need for all city agencies to come together in order to support our most vulnerable New Yorkers, not just those that provide mental

health and aging services, but across all the sectors represented in the Cabinet.

We share the Council's aims to make New York City a great place to grow old. If a city defines its worth by the way it treats older adults, then this bill may bring us closer to that goal. To that end, greater investments to support the mental health needs of older New Yorkers are critically needed in this budget.

Thank you for your work on behalf of all older New Yorkers and for this opportunity to testify.

CHAIRPERSON HUDSON: Thank you so much.

ANITA KWOK: Thank you, Chairs Hudson and Lee, for convening today's joint hearing on Older Adults and Mental Health. My name is Anita Kwok, a Policy Analyst for representing United Neighborhood Houses, a policy and advocacy organization representing neighborhood settlement houses.

Our members provide a wide variety of services to over 800,000 older New Yorkers each year by operating programs such as those for older adults and behavioral mental health services.

Many older adults served by settlement houses are low-income immigrants with limited access to food, housing, healthcare, and mental health services. Language barriers and mental health stigma further prevent them from seeking support. Settlement house staff are essential to the community, assisting older adults in navigating complex welfare systems, such as benefits enrollment and access to care.

UNH is a long-time supporter of the Council's Older Adults Mental Health Initiative, which makes mental health services accessible by putting them in community spaces where older adults already gather, such as senior centers, NORCs, and food pantries. It increases the capacity of CBOs serving older adults in identifying mental health needs, providing immediate mental health intervention, and referring clients to further psychiatric treatment when necessary.

With recipients of this funding observing rising levels of social isolation, bereavement, and fear among immigrant populations, CBOs are able to meet their clients where they're at, which is often in nonclinical settings like churches, which Chair Lee mentioned during questioning.

Given the vast success of this program, we urge the Council to restore full funding to the Older Adults Mental Health Initiative of $3.5 million in FY26, which includes a 3% COLA to match the citywide human services COLA.

Our members have also observed an increase in fear among older adult immigrant populations, because of the anti-immigrant rhetoric and polices by the new federal administration. Furthermore, unpredictable federal policy proposals have placed additional strain on aging services providers. Earlier this year, a proposed elimination of Social Security phone services would have forced millions of older adults to seek in-person help (TIMER), even as staffing was being cut. Settlement house staff scrambled to prepare for surging client needs. Although this policy was rescinded, ongoing SSA staff cuts and frequent website outages continue to make accessing services difficult, compounding the burden on frontline providers.

UNH urges the Council to pass Council Member Shekar Krishnan’s Resolution 852, calling on the United States Congress and the President to take

steps to protect Social Security. Thank you for your time.

CHAIRPERSON HUDSON: Thank you so much. Thank you both for your testimonies.

Okay, I will call the next panel: Chelsea Rose, Jeannine Cahill-Jackson, Navdeep Bains, and Emma Bessire.

(PAUSE)

CHAIRPERSON HUDSON: Anyone can begin, and then we will just go down the line.

EMMA BESSIRE: Hi, and thank you for the opportunity to testify today on the topic of mental health and older adults, and to the Chairs for holding this important hearing.

My name is Emma Bessire, and I am the Senior Associate of Policy and Advocacy representing City Meals on Wheels. The issue of mental health is of particular importance for Citymeals due to the heightened rates of social isolation among older adults who are homebound experience and the consequences of that. Numerous studies have found a link between being homebound and not just social isolation, but depression and a broad range of

medical and psychological conditions, as Chair Lee mentioned earlier in this hearing.

In a recent study of over 500 older New Yorkers participating in congregate and home delivered meal programs, we learned that not only were half experiencing food insecurity, but more than 50% lived alone. We also learned about their mental health concerns and their access to support, such as that 38% of participants reported that loneliness and depression were problems for them. And yet, a staggering 82% never accessed mental health services. Forty-five percent of older New Yorkers reported having little to no support from family, friends, or a personal care attendant for meals, which suggests that they may not have that same support for other types of needs that they have. A majority also live on $15,000 a year or less annually, and 25% reported not knowing about general support services available to them.

These data suggest that not only is there a need for programs that address depression, loneliness, and other psychological conditions among older adults, especially those who are homebound, but

there's also a gap in existing supports and access to them.

We urge the Council to restore full funding to the geriatric mental health initiative at $3.5 million in FY26. The initiative provides critical screenings, referrals, counseling, and more, and it's vital to meeting older adults where they're most comfortable and fulfilling their mental health needs.

The virtual and telephonic options are particularly critical for homebound older adults who may not regularly attend an OAC or have access to in-person mental health services, but can be referred through their case manager. (TIMER)

A further investment of $800 million is also needed in order to address critical infrastructure issues at older adult centers across the city. Older adults deserve to access mental health services and centers that are accessible and in good repair.

We thank the Council for their efforts to support the mental health of older adults through this hearing, and urge you to adequately fund the programs older adults so desperately need.

CHAIRPERSON HUDSON: Thank you so much.

NAVDEEP BAINS: Thank you, Chair Crystal Hudson and the Committee on Aging, as well as Chair Linda Lee and the Committee on Mental Health, Disabilities and Addiction for holding this hearing and for giving us the opportunity to testify about the mental health needs of older New Yorkers. I am Navdeep Bains, Associate Director of Advocacy & Policy at the Asian American Federation (AAF), where we proudly represent the collective voice of more than 70 member nonprofit organizations serving 1.5 million Asian New Yorkers.

As the Asian community faces a challenging landscape due to federal funding cuts and anti-immigration policies, our older adults are placed at the center of this issue, with the intersection of race and age rendering them particularly vulnerable. While our member organizations continue providing high-quality mental health care, this increased demand, coupled with challenges in obtaining and retaining culturally and linguistically competent staff, has resulted in increased strain on our CBOs. Without these essential nonprofit organizations and their lifesaving direct services, our older adults

would experience increased adverse mental health outcomes.

Asian older adults are the fastest-growing older adult community citywide, making up 14% of New York City's senior population. This population growth was coupled with a rise in poverty, and currently, 42% of Asian seniors are low-income. Moreover, 25% of Asian seniors experiencing poverty live alone, and 84% have limited English proficiency - this results in a high likelihood of isolation and loneliness, and these are key issues that our CBOs on the ground address daily with the support of the City Council, for sure.

The topic of today's hearing is particularly important to AAF as we convene the Seniors Working Group and a Mental Health Roundtable. They are both working groups that we get together with our CBOs doing this work on the ground. They represent the voice of over a dozen different CBOs, serving more than a dozen distinct Asian ethnicities in the community.

So, we are in support of the City Council's measures discussed today. We have been longtime supporters of Chair Crystal Hudson's Age in Place

legislative package, including the proposal discussed today. (TIMER) We also support Resolution 106, because programs like this protect seniors from never ending rent hikes in a time of economic crisis, and (INAUDIBLE) safety programs threats to social safety net programs and social security. Expanding the eligibility of this program, which is the Disability Rent Increase Exemption program, to include additional qualifying members will help seniors in the Asian community from facing an immense hardship and stress, such as eviction and houselessness, and it would also help their family members who are also experiencing vulnerable situations.

I just want to also mention that we are in support of Council Member Krishnan's Resolution 852, because many members of the Asian community rely on Social Security to pay for basic necessities like groceries, utility bills, and housing. For our older adults, this is the only source of income they can rely on. Protecting Social Security will not only provide a steady source of income to our Asian seniors but will also prevent worsening mental health crises from stress and anxiety.

One of our member organizations, which serves the community in Brooklyn, states that Social Security cuts for seniors have been a major topic of concern and discussion at their senior center and older adult center. Their attorneys in-house are doing workshops and training for the community, because they are confused about what they qualify for and what might be cut, and cause increased poverty.

So, thank you so much to the Council for supporting AAF's older adult initiatives, so that we can continue to do advocacy, research, and programming work in this area, as well as our immigration rapid response work, which we are hoping to continue to get support from well into the next year, because their needs are continuing to grow. Thank you so much.

CHAIRPERSON HUDSON: Absolutely, thank you so much.

CHELSEA ROSE: Good afternoon, my name is Chelsea Rose, and I serve as the Policy and Advocacy Manager at Care For the Homeless (CFH). I want to thank the Committee Members for the opportunity to testify today.

CFH has as over 40 years of experience delivering medical and behavioral healthcare exclusively to people experiencing homelessness in New York City. We operate 22 federally qualified health centers in shelters, drop-in centers, and soup kitchens. We also run five shelters with onsite health services. Across our programs, our goal is to end homelessness by providing supportive services that help residents move into stable housing.

Today, I want to focus on a specific and growing population within New York City's shelter system: older adults living with serious mental and cognitive disabilities and requiring a higher level of care than what is available in shelters. Facilities that could support them, such as adult homes, assisted living, and nursing homes, are frequently inaccessible. Many reject applicants with psychiatric diagnoses, or don't have space, even those who are clinically eligible, can wait years for placement. In the meantime, too many aging and disabled New Yorkers remain in the shelter system, receiving fragmented and insufficient care.

Residents at one of our shelters describe watching older women cycle endlessly between

emergency rooms and shelters, struggling with basic daily activities like bathing, eating, and dressing. They have watched their mental and physical health deteriorate in real time as they are living in a system that was not built for them.

The following are some of their testimonials:

- "Residents are acting as nurses for each other to keep them from going back into the hospital."
- "Before entering the shelter system, I had a home aide that helped me bathe and take care of myself. Now I can't take showers because I can't bathe on my own."
- "I go into the hospital like a revolving door. And then they send me right back here."

These stories are not isolated. Without better pathways to long-term care, more aging New Yorkers will be trapped in systems that fail them, without stability, without care, and without dignity; this is not only a policy failure but a moral one.

Thank you very much for your time and your commitment to the health, safety, and dignity of all New Yorkers.

CHAIRPERSON HUDSON: Thank you so much.

(TIMER) Right on time.

(LAUGHTER)

JEANNINE CAHILL-JACKSON: Good afternoon, Chair Hudson, Chair Lee, and Members of the Committee. I am Jeannine Cahill-Jackson, Director of the Elder Law Unit with the Legal Aid Society. I am here today with many of my colleagues from the Bronx neighborhood office.

Legal Aid is in support of all of the proposed bills and resolutions on the agenda today. But the one I wanted to focus in on during my spoken testimony is the Proposed Introduction Number 1257-2025. This is a very important study. We first suggest that the Cabinet should speak to legal services providers and other CBOs in addition to the other city agencies. Because these folks work with seniors with neurological and mental health conditions on a daily basis, and are very familiar with helping them try to access the city services that the Cabinet might be thinking of finding the issues with them being able to connect with (sic).

In our work, we encounter seniors with mental health conditions, as well as cognitive decline, and

they often struggle to access services. The one that really stands out to me the most is seniors with hoarding disorder. Adult Protective Services is the only organization that can help them with this. Still, the only service that is provided for these seniors is called a "deep clean," which is a rather traumatic removal of all of their possessions. It is actually not in line with any trauma-informed or client-centered treatment. There are no supportive services or mental health services provided for the senior, nor any alternative options, such as decluttering. And the process is traumatic at worst and disempowering at best.

In addition, folks with cognitive decline also struggle to access APS services. For example, they have not only to hear the knock on the door, understand to open it, and then be able to engage with the case worker. However, if they are not home at the time, the onus is on them to connect by calling the case worker and understanding (TIMER) the number on the business card.

May I continue with just a few more points? Thank you.

This process is very challenging for these seniors and even for them to remember to do if they have short-term memory issues.

Additionally, and I believe this came up earlier in the hearing, if the senior is experiencing Alzheimer's or dementia, they may not present as having cognitive decline, but be demonstrating it through what they are sharing.

Recently, we had a client who was denied Adult Protective Services a few times because he clearly explained that every month, he writes out a check and puts it in the landlord’s drop box. And he was able to go grocery shopping, et cetera, but in fact, he hadn’t had food in the fridge for months, and hadn’t paid rent in over five years. But he was not aware that he was not accurately reporting. There was no further investigation; the case was closed after that initial assessment was done in the apartment. On paper, it may seem sufficient, but often a bit more investigation is needed, perhaps by verifying with collateral resources like family members or even the neighbors that you were referencing -- just to help see if this is someone telling the story of them managing their affairs, or

explaining to you how they used to be able to and they don't know that they are no longer able to.

So, I will conclude with that last example. We will also provide written testimony to address a few issues, such as accessing CityFHEPS renewals and the process for Access-A-Ride. We will definitely include some client examples in our written testimony. Thank you so much for your time today.

CHAIRPERSON HUDSON: Thank you all so much for your testimonies. And just one second, I know Chair Lee has a question.

CHAIRPERSON LEE: So, actually, two questions for each of you.

For Chelsea, 22 federally qualified health centers is no small feat. That is a lot of work. I can just imagine how many people you have going in and out of the help centers. I was just wondering if you could speak more to -- because I think the biggest frustration, or at least my biggest pet peeve, and I am sure the same goes for Chair Hudson, are the silos that we have in government. It is hard to move people through the system and throughout different services. I'm curious to hear more about how you're integrating the model. And if you could

speak more to that in terms of how you are doing the FQHC clinics. And I know that you have the separate shelters. So, how are you sort of integrating the care for that?

CHELSEA ROSE: So we collocate in the majority of those 22 federally qualified health centers, besides the five shelters that we run. We partner with other organizations, and we do soup kitchens and drop-in centers, where people experiencing homelessness are already accessing services. And then, depending on the population we are serving, for example, at assessment sites or sites focused on getting chronically street homeless individuals off the street, that care will be more short-term, getting them stabilized and integrated into the shelter system. Whereas at our shelters, we are able to provide more long-term care. Ultimately, the goal is to get them to regularly get to primary care, dentistry, and behavioral health appointments. But, due to cuts coming down from the federal government, and just generally in this sector, we struggle with staff retention and maintaining these health centers and good quality care that, depending on the shelter and the number of staff we have on board, our health

centers struggle to maintain that quality of care that I think many people, especially older adults in our shelter system, need.

CHAIRPERSON LEE: Mm-hmm.

CHELSEA ROSE: And ultimately, it is by their appointment base for many of these health centers. So, for the individuals I spoke to who informed this testimony, these are individuals who need care 24/7. They need to be reminded to take their medication, they need help bathing, and that is not something our health centers -- and with the partnerships with our shelter, that is not a service that we necessarily can provide.

CHAIRPERSON LEE: Then, do you also have any other contracts for the street mobile outreach teams? Because I could see how that would be a great transition into your services as well.

CHELSEA ROSE: We do have some outreach teams. And I'm happy to talk more in detail about our various sites and how each of them works. But, yes, we do have some street outreach that focuses on bringing people into assessment sites and drop-in sites and whatnot.

CHAIRPERSON LEE: Okay. Just really quickly for Jeannine, I am curious to hear what your recommendation would be for this? Because there is only, as you said, one program to just declutter. But that's not addressing the actual issue. So, have there been recommendations from different advocacy groups that have said, hey, if you were to create this agency, or if we were to integrate some other models within, for example, DSS, what have been some of the recommendations that you all have suggested?

JEANNINE CAHILL-JACKSON: I can't speak to whether or not the recommendations have been formally made, but I can get the actual name of the different kinds of therapeutic models and things like that and include it in my written testimony. But, in theory, this could happen under Adult Protective Services as well. Currently, if someone is hoarding in their apartment, it's referred to as a "deep clean." Essentially, it's just a junk removal service that comes in. I mean, not junk, it is a big feat for the individuals that do that work, but we are also speaking about mental health diagnoses. And hoarding disorder is a clinically recognized mental health diagnosis. So there isn't any treatment provided or

even a clinical assessment. Well, perhaps there might be a clinical assessment in the psychiatric evaluation, but there isn't a related treatment for the individual, nor is what's carried out clinically informed. So, they go in and they remove all of the individual's belongings. They can flag a couple of nominal things that they want to save, but there are other processes that are more clinically informed. For example, there could be actual mental health support for the individual throughout the process, because it is very traumatic. There is often underlying trauma that leads people to hoard — loss, grief, things like that. So it is often a manifestation of something that they have already gone through. Then the process itself is traumatic, and there is no ongoing support for them, so they also run the risk of hoarding again, and have all of their possessions taken from them again. And if they don't, then they face either eviction, because that is often when we are seeing them, there is a holdover case, they're in housing court facing eviction, so it is either they lose their home, and end up in a shelter, or give up all of their possessions. And unless you have a lot of means -- so they are also

companies that do work with clinicians, where you have to pay $5,000, $10,000, so you have to be a person of means to even engage with these companies. At times, we have tried to secure funding for a particular client for this purpose, but as a nonprofit legal services provider, finding outside funding for $10,000, that is a sizable amount of money. So it is not available to a lot of low-income New Yorkers.

CHAIRPERSON HUDSON: Thank you.

JEANNINE CAHILL-JACKSON: Thank you.

CHAIRPERSON HUDSON: Thank you all.

The next panel is Ronald Johnson, Fiodhna O'Grady, Kumarie Cruz, and Christopher Leon Johnson.

(PAUSE)

CHRISTOPHER LEON JOHNSON: Yeah, I'm gonna go first, because I got things to do. I know, it's kind of... Can I go?

CHAIRPERSON HUDSON: Go for it.

CHRISTOPHER LEON JOHNSON: Yeah, uhm, hello, Chairs Hudson and Lee. Thank you for having this hearing today. I am here to show my support for Chairperson Krishnan's bill. And the reason I'm showing my support is because we have to make sure

that the people that are living on Social Security do not get their money cut. I have a big feeling that Donald Trump, who is our president, is doing this because he wants to fund ICE. Well, at the same time, the reason I'm showing these posters, I hope I don't be off topic, is because of that... we have to make sure that ICE does not get funded with federal money. I am calling the City Council to make sure that they work together.... they work with the Speaker to Trump-proof New York City. I know you can Trump-proof New York State, but you can Trump-proof New York City by making sure that Social Security is funded no matter what happens. You can take some of this money out and help fund the... You should make budgets to fund these older people. We have to make sure that we stand by our migrants. We have to stand with our migrants, because this is nothing but to hurt immigrants. They take this money out of Social Security just to fund ICE, so they can deport the migrants -- deport good migrants. Not the bad ones. Just only the good ones. So, I am calling on the City Council to really come forward and Trump-proof New York City. Stand with our migrants.

And one more thing about the (INAUDIBLE) situation. What we need to do is put an initiative, like a subcommittee, in the City Council to designate for young mental health. I mean, not only for older mental health, we need to designate a subcommittee. I hope that's on you, Mrs. Linda Lee, or to appoint, like, Erik Bottcher, who's here, he's not a committee chair. I think he should need to make a committee dedicated for young mental health. He's a millennial. I mean, he should lead that committee. Not only just for.. I understand we got DYCD, the committee held by Althea Stevens, but at the same time, we need to have a subcommittee dedicated only for millennials and Gen-Z. And I believe that Erik Bottcher would be the perfect person to lead that committee. I hope you have that in next year's budget. (TIMER) So, thank you. I got to go downstairs for the rally.

CHAIRPERSON HUDSON: Thank you so much.

CHRISTOPHER LEON JOHNSON: Thank you. (INAUDIBLE) (LAUGHTER)

KUMARIE CRUZ: Good afternoon, and thank you, Chairs Lee and Hudson, for the opportunity to testify.

My name is Kumarie Cruz, and I am the Director of our Public Education program, as well as our Bereavement Services at Samaritans. In my role, I help to support those who have lost loved ones to suicide, and I help to train professionals across the city, including senior center staff, case managers, and caregivers, on how to recognize and respond to suicide risk.

We support Introduction Number 1257, because it brings long-overdue attention to how agencies are — or aren't — serving older adults living with mental health or neurological conditions. Our team often hears from seniors who feel they're falling through the cracks, they're misunderstood, overlooked, and dismissed by systems that are not necessarily designed with them in mind.

But the value of this bill lies not just in the data it gathers, but in whether that information leads to meaningful change. That change depends on genuine engagement with those who understand the realities on the ground: the community-based organizations, like ourselves, other dedicated caregivers, as well as the older adults themselves.

These Resolutions, 106-A and 852, are also directly tied to suicide prevention. Financial insecurity is a major driver of anxiety, fear, and distress, especially among older adults. This would help protect against housing instability, which is a common trigger for crisis, while safeguarding Social Security benefits ensures older New Yorkers can maintain not just financial stability, but a sense of dignity and independence.

A person's worth doesn't diminish with age. We see, oftentimes, the (TIMER) misconception that aging and sadness are oftentimes going hand and hand -- that it goes hand in hand with aging — depression. But every adult has a story, they have relationships, and a right to support. Many of them tell us that they feel like a burden, that no one would notice if they're gone, that their pain is really just part of getting old. And those are some of the huge misconceptions that have to reject. And these bills help to do that. Every adult to speak to is a reminder that suicide prevention must extend across the lifespan. These proposed policies move us closer to that reality. Thank you again for your time.

CHAIRPERSON HUDSON: Thank you.

FIODHNA O'GRADY: Hello, my name is Fiodhna O'Grady, and I serve as Director of Government Relations working with Kumarie at the Samaritans of New York. Chair Lee, thank you; you're very used to us coming to the Mental Health Committee over many years, but it's exciting to actually be here with Chair Hudson, as the topic of aging and suicide is a very important one. And I think you have some of the stats from our handout, which we just gave you, which is that older adults tend to plan out suicides more carefully.

CHAIRPERSON HUDSON: Mmmm...

FIODHNA O'GRADY: And therefore, they utilize more lethal means. And they also complete suicide much more than many other age groups. And they are less likely to recover from an attempt. Older adults may exhibit passive help, self-harm behaviors, such as eating less, going out less, and doing things less. So there is also a misconception that aging, sadness, and depression go hand in hand with aging. And as you spoke about all day, it is a misnomer. And it reduces the likelihood of identifying risk. And we assume that older adults, it is nearly okay, you know, there is a discussion around suicide and

getting older, but there is also suicide prevention. So, both of these truths can be there, and we have to figure out where people are and go to them, you know, to assess what need they have. So we strongly Introduction 1257, particularly for expanding eligibility for housing support and protecting social services. We also agree with the study proposed. But we do urge the Council to ensure it is not only robust but also actionable, and that you start to include the word "suicide" in these discussions around aging. It is a myth, and it is a difficult word across all age groups, but I think especially for adults, because (TIMER) we think of them on their way to dying, therefore it doesn't seem to be so bad for them to be suicidal. But that is actually another myth and a misconception. So, you all know that we're really pleased to be here with Aging, and we'd love to interact. We did have some conversations with your Legislative Fellow during the Budget hearings, et cetera. We would like to get closer to your staff and everything, and we will over the summer and autumn.

CHAIRPERSON HUDSON: That sounds good, thank you. Thank you both so much.

RONALD JOHNSON: Good afternoon...

CHAIRPERSON HUDSON: Just press the button there at the bottom. Yep.

RONALD JOHNSON: Oh, thank you.

Good afternoon, Chair Lee, Chair Hudson, I appreciate the opportunity to come before you, although I have a personal testimony, I believe I speak for New York City correction officers past, present, and the future, who were injured in the line of duty. It is an egregious ruling how the New York City department treats officers who go in every day, they put their lives on the line, and they deny them full disability based on interaction, engagement, or altercation with an inmate. I myself personally was performing my duties as a New York City correction officer, and I suffered an injury, and I was denied full disability based on what I believe are arbitrary, discriminatory rulings. I believe that correction officers already have a tough job, and many people don't know what goes on inside. I worked in Rikers Island, AMKC, which was the largest facility on Rikers Island, and correction officers, it's a thankless job. It's a thankless job. No one sees the ins and outs. Each day we walk into that facility with a uniform on, we put our lives on the

line. A correction officer is always in the line of duty, whether you're doing eight hours or 16 hours. So I believe it is totally unfair for the department to base a disability based on your engagement or interaction with an inmate. I beg of the Committee to please look into somehow bringing in legislation to change this. Look at cases independently. Because, again, I know when I came in in 1991, correction officers were primarily Black and brown. (TIMER) And now, knowing these stipulations placed on them, I can't in good faith tell anyone, hey, listen, it's a great job now. You know, who wants to walk into a facility knowing that an inmate dictates your disability? And also with these rulings, you put correction officers, civilian staff, as well as inmates in danger because with these rulings, you're hesitant to act. And we know in that environment, you have little time to act upon a situation.

So again, I thank you for hearing me. I believe this matter is important to all those officers who don their uniform every day. And I believe I speak for many of them. I speak to officers daily, and I have friends now. It's just egregious, knowing the difference between full disability and

what we would say one-third disability is, is dependent on engagement with an inmate.

Thank you, I appreciate your time.

CHAIRPERSON HUDSON: Thank you so. Can we just get your contact information? You can come up to the table.

RONALD JOHNSON: Right now?

CHAIRPERSON HUDSON: Yeah.

RONALD JOHNSON: Okay, thank you.

CHAIRPERSON HUDSON: That way, we can just follow up with you directly. Thanks

(PAUSE)

CHAIRPERSON HUDSON: We will now move to virtual testimony. Please wait for your name to be called to testify, and please select "unmute" when prompted. Saaif Alam?

SAAIF ALAM: Yes, hi, good afternoon, Chair Lee, Chair Hudson, and everyone in the Committee.

My name is Saaif Alam, and I am one of the civic leaders in Jamaica Hills, Queens, where I work closely with community members, advocacy groups, and local organizations to uplift the voices of our most vulnerable neighbors, especially seniors, people with disabilities, and working-class families.

I am here today to raise deep concerns about the threats to Social Security, particularly following proposals from our current US presidential administration that aim to cut or weaken this essential program.

In Jamaica Hills, we have a significant senior population, many of whom are immigrants, retired public servants, essential workers, and caregivers. These residents rely on Social Security as their primary or only source of income. It covers their rent, medication, food, and transportation. There's no safety net beyond that monthly check. If the federal government proceeds with any cuts to Social Security, our seniors in Queens, especially those in Jamaica Hills, will face real, immediate harm. As costs of living rise and affordable housing becomes scarcer, any reduction in Social Security is not just unjust, it's dangerous. While Social Security is federally administered, I urge this Council to take a clear and vocal stance. I respectfully ask that you: Pass a formal resolution condemning any federal attempt to cut or privatize Social Security; Increase city level support for older adults, including outreach, to help them access

their full benefits and housing protections; fund legal and benefits advocacy programs, so seniors, particularly immigrants and non-English speakers, are not left behind; and work with New York's Congressional Delegation to make the City's position clear. We will not accept cuts to a program (TIMER) that keeps our communities afloat.

SERGEANT AT ARMS: Your time...

SAAIF ALAM: Our seniors built this city...

SERGEANT AT ARMS: Your time has expired.

SAAIF ALAM: Can you give me a few more minutes, 30 seconds to finish?

CHAIRPERSON HOLDEN: Thirty seconds, absolutely.

SAAIF ALAM: Our seniors built this city. They worked in our cities, cared for our families, and paved the way for the generations that followed. As one of their civic leaders in Queens, in Jamaica Hills, I feel a deep obligation to ensure we fight for their dignity, their security, and their rightful place in our future.

Thank you for the opportunity to speak today, and we look forward to working with the Council to protect our neighbors. Thank you

CHAIRPERSON HUDSON: Thank you so much.

I would also like to acknowledge that Council Member Salaam has joined the hearing.

I would like to call the next few names who have registered for questions or for testimony: Armando Rodriguez, Alex Stein, Gordon Lee, and Dante Bravo. If any of you are online, please unmute yourselves, and we will begin the countdown.

Okay, seeing no one online, we would like to close the hearing. Thank you to everyone who provided testimony today. This is such an important topic, especially as we see the older adult population increasing by 40% in New York City here over the next 15 years. Thank you again to Chair Lee for her steadfast partnership.

This hearing is now adjourned. [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 July 11, 2025