NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Alister F. Martin, MD, MPP
Health Commissioner

Testimony

of

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

before the

New York City Council

Committee on Mental Health and Substance Use

On

Oversight: From Crisis to Care: How New York City Connects New Yorkers to Mental Health Services; Pre-considered Introduction T2023-3879

March 4, 2026
250 Broadway, Hearing Room 2
New York, NY

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

We recognize that mental health is central to overall health. We put this into action by employing a public health approach to supporting the mental and behavioral health needs of all New Yorkers. We serve as the City's mental health strategist and work with more than 200 community providers to deliver over 800 programs.

We also recognize that we are working within a complex and imperfect system, in this city and country. This work exists within a context shaped by historic injustices. We are committed to working every single day with providers, communities, experts, and families to improve the mental health system and support all New Yorkers.

Today, I'll discuss two important pillars of the continuum of programs we support: crisis services, which are short term interventions for all New Yorkers, and mobile treatment, which are long term interventions for the highest need New Yorkers.

Crisis Services

What constitutes a "Mental Health Crisis" can look very different from person to person. You do not need a diagnosable mental illness or serious mental illness. A crisis may be triggered by a myriad of different internal emotional or cognitive experiences, interpersonal conflicts, including abuse or violence, or environmental stressors such neighborhood safety. It is essential to recognize the complexity and nuances of these experiences in this discussion.

Providing support in moments of mental health crisis is a tremendous duty that we share with our city and state partners. My colleague from the Mayor's Office of Community Mental Health are here today to answer questions regarding the BHEARD program, which is an important part of the mental health care continuum. I will speak to the crisis response infrastructure that the Health Department directly administers.

Crisis services we support can be categorized into three groups: *Someone to Call, Someone to Respond, and Somewhere to Go.*

NYC 988 is that *Someone to Call* for every single New Yorker.

When someone experiences a mental health crisis, it can be helpful to talk to someone we trust: a friend or family member, a religious advisor, a peer, a mental health professional or health care provider. Anyone can reach out to NYC 988 at any time of day or night, any day of the year, to speak with a trained crisis counselor or peer support specialist. New Yorkers can reach out via call, text, or chat.

NYC 988 counselors and peers will listen to a person's situation and help them through a moment of crisis with emotional support and coping skills. NYC 988 provides counseling and local resources consistent with national standards and best practices.

Counselors help connect people to ongoing mental health services that meet their needs. In New York City, these counselors refer people who don't need immediate care to community based mental health providers and community resources. There is also an online database of service providers available to the public on the NYC 988 website.

Sometimes, a person may be unable or unwilling to seek mental health services to get through their crisis. This brings me to *Someone to Respond.*

In these situations, NYC 988 will dispatch a Mobile Crisis Team (MCT) to visit the person wherever they live within a few hours, 8 am – 8 pm, 7 days a week, citywide. Mobile Crisis Teams are our cornerstone short term intervention for non-life-threatening mental health crises. Mobile Crisis Teams represent a significant portion of the mental health crisis response infrastructure in the city. In FY25, over 18,000 referrals were made to Mobile Crisis Teams. The city is currently served by 25 Mobile Crisis Teams, 22 of which are contracted by the Health Department.

Mobile Crisis Teams include both master's-level mental health clinicians and peer specialists. They meet face-to-face with the identified individual in crisis, as well as their family or other support systems, to engage, assess, de-escalate and connect individuals to the most appropriate services. Meetings typically occur wherever the person resides, such as a private apartment, a supportive housing setting or emergency shelter. After a crisis is de-escalated, people can be connected to out- or in-patient care if appropriate. We consider Mobile Crisis Teams a short-term intervention, typically ranging from 1-3 contacts in a two-week period.

Some people need more support than they can access in their home. These folks might need *Somewhere to Go*, our third and final category of mental health crisis services.

For these situations, Crisis Residences provide an alternative to hospitalization for people experiencing mental health crises. They are warm, safe and supportive home-like places that offer 24-hour peer support, group activities, and connection to clinical services as needed. Guests typically can stay for up to one week. These open-door settings enable people to remain connected to their lives—school, work, family—while getting additional supports through a crisis. People may be referred to a crisis residence by NYC 988, a Mobile Crisis Team, their mental health provider, or through self-referral.

For continued support and treatment, all of these programs can connect New Yorkers to outpatient clinics and community-based services. For the subset of people served by mental health programs who are homeless, service providers assist with referrals to supportive housing, of which the health department contracts over 13,000 units.

For those in need of long-term care that extends beyond clinic walls, we have mobile treatment programs that allow providers to literally meet people where they are.

Mobile Treatment – Long Term Interventions for the Highest Need NYers

Mobile treatment programs are specialty care designed to serve people with the most complex behavioral health needs. We use the term Serious Mental Illness to refer to this combination of behavioral health and functional needs. These are long term interventions for a small subset of high need New Yorkers; unlike the crisis services I previously described.

The Health Department manages the referral system for these specialty services, New York City's Single Point of Access (SPOA), and contracts with community based organizations and hospitals to administer services, namely Assertive Community Treatment (ACT) and Intensive Mobile Treatment (IMT) Teams.

Providers make referrals to SPOA through our website. Referral sources include the crisis services providers I just described, as well as community based mental health, shelter, and housing providers who recognize that their client could benefit from a higher level of care. Hospitals, jails and prisons also make referrals to SPOA, as a part of their discharge planning process.

Clinicians at the Health Department's SPOA review eligibility and assign people to the appropriate level and location of care. The SPOA system received 4,952 referrals in FY25. Our clinicians will determine if someone is eligible for ACT and IMT, which have a combined capacity to serve about 6,500 people at a time.

ACT is an international evidenced based model that provides mobile, community based mental health and substance use treatment to people with serious mental illness, whose needs have not been met by clinic-based care. Teams are multidisciplinary, comprised of peers, social workers, psychiatrists and nurses who will visit clients wherever they live to administer medication and support clients in achieving goals such as housing and job placement.

ACT teams are licensed by the State Office of Mental Health (OMH) and contracted by both OMH and the Health Department. In NYC, there are 80 teams serving approximately 5,500 New Yorkers. ACT teams are operated by a total of 20 community-based-organizations and 15 hospitals, including NYC Health and Hospitals, state operated psychiatric centers, and private hospitals.

Some of these teams specialize in certain populations. Six Forensic ACT teams work exclusively with eligible individuals with current or past criminal legal involvement. Ten Shelter Partnered ACT teams work exclusively with eligible individuals residing in mental health shelters.

IMT provides mobile treatment like ACT but was created by the Health Department in 2016. IMT serves people with more complex cross system involvement, housing instability and transience - who sometimes have more complex, or less clear, behavioral health diagnoses.

Multidisciplinary IMT teams include behavioral health clinicians and peer specialists who bring services to wherever participants are in the community - the street corner, a shelter or a residential setting.

IMT provides mental health and substance use treatment, including medication, care coordination, and behavioral health support. The teams individualize service frequency and duration, and participants may stay in the program as long as they require the supports. IMT teams may also continue to provide services to participants during hospitalization, incarceration, and residential substance use related rehabilitation to promote continuity of care.

Our mobile treatment programs accessible through SPOA (ACT and IMT) are distinct from crisis services. Both are essential interventions that address different needs and play pivotal roles in the continuum of mental health care.

I will now turn to the legislation, before answering questions.

Pre-introduction T2023-3879, refers to the establishment of a taskforce on 988 and a public education campaign. We support the intent of the bill and look forward to further conversations about how existing efforts meet these needs. The Health Department is planning multiple 988 and mental health awareness campaigns this year. Additionally, there are mechanisms in place to improve the NYC 988 program, which includes stakeholder and community input.

The Health Department is deeply committed to this work and has been for decades. I want to thank the providers who carry out this important and challenging work every single day. I am pleased with the progress we have made, but we still have so much more work to do. Thank you for the opportunity to testify today. I look forward to answering your questions.

New York City Council Hearing Testimony

Mayor's Office of Community Mental Health

March 4, 2026

Good morning, Chair Caban and members of the Committee on Mental Health and Substance Abuse. I am Laquisha Grant, Deputy Executive Director of Mental Health Access for the Mayor's Office of Community Mental Health (OCMH). Thank you for the opportunity to testify on Int. 722 and answer any questions about our critical role in addressing mental health needs in our city.

The Mayor's Office of Community Mental Health (OCMH) works to develop scalable approaches to mental health care by bridging policy, clinical practice, and community expertise—all with the goal of improving mental health outcomes for all New Yorkers and strengthening access to the supports they need to live healthy and fulfilling lives. Codified into the City Charter in 2021, OCMH is also tasked with identifying gaps in care and driving evidence-based interventions and policies to meet the needs of all New Yorkers.

OCMH appreciates the intent of Int. 722 to enhance transparency and public understanding of how mental health emergency calls are resolved across City agencies. We share the Committee's commitment to accountability and to transparency as it relates to how the city is responding to mental health emergencies. At the same time, we must respectfully note significant operational and legal considerations associated with the bill's current reporting requirements as written.

OCMH along with FDNY, in their position as a healthcare provider for the B-HEARD program, have substantive concerns regarding patient privacy and data integrity. The bill references treatment-related information and data elements—such as medical treatment on scene, voluntary versus involuntary transport, crisis counseling provided, and referrals to community-based providers. In the health data context, these elements reflect an individual's interaction with emergency medical services and the mental health system. When they are linked to a unique identifier rather than presented in aggregate, it may constitute Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA). Requiring the publication of unique identifiers alongside treatment-related data on OCMH's website and the Open Data portal presents a meaningful risk of re-identification and associated HIPAA liability. Even without unique identifiers, the required data points (including precise location) could easily be connected and traced to individuals, especially in residential buildings, exposing the identities of New Yorkers during their most private and sensitive moments. An individual's risk (real or perceived) of being identified in a dataset such as this weakens trust and may dissuade individuals from calling 9-1-1 in times of need, thus endangering public health and safety. We respectfully recommend careful legal review of these provisions and welcome continued collaboration with the Committee

and our partner agencies to advance transparency goals while safeguarding patient privacy and preserving the integrity of sensitive health data.

Further, the legislation would require reconciliation of roughly 160,000 mental health-related calls each year across multiple distinct and non-integrated systems operated by the New York City Police Department, the Fire Department of the City of New York, NYC Health + Hospitals, and private hospitals that provide voluntary ambulances in the 911 system. Compliance with Int. 722 would necessitate the hiring of data staff to design and maintain interagency data pipelines, conduct cross-system reconciliation, validation/analysis, and oversee data governance to ensure adherence to applicable legal standards. In addition, the bill would likely require investment in secure, HIPAA-compliant technology infrastructure, a data integration platform, as well as data reporting and dashboarding tools. Finally, there is no single 911 call type that encompasses every "mental health emergency," and calls sometimes get reclassified in the course of the response. The terminology should be refined to better align with operational realities.

In closing, we thank the Chair and Members of the Committee for your continued leadership and partnership on issues affecting the mental health and well-being of New Yorkers. OCMH remains firmly committed to advancing a health–centered approach to crisis response—one that provides New Yorkers with the most effective and compassionate care at their moments of need, promotes transparency, protects patient privacy, strengthens interagency coordination, and builds systems that are equitable and sustainable. We look forward to continued collaboration with the Council to ensure that our collective efforts enhance accountability while upholding our shared responsibility to safeguard the health, dignity, and safety of all New Yorkers.

New York City Independent Budget Office

TESTIMONY

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March 4, 2026
Testimony of Cassandra Stuart, Lead Budget and Policy Analyst
On behalf of New York City Independent Budget Office
to the New York City Council Committee on
Mental Health and Substance Use

Good morning, Chair Cabán and members of the Committee. I am Cassandra Stuart, Lead Budget and Policy Analyst on Health at the New York City Independent Budget Office (IBO). I am joined today by my colleague Ed Dolan who is a Senior Policy Advisor at IBO. I appreciate the opportunity to discuss some of the findings of IBO's January 29, 2026 report on the Behavioral Health Emergency Assistance and Response Division (B-HEARD) with you today. The report focused on B-HEARD operations and identified several factors that must be considered for optimal performance, both for the current program size and if the program expands. A companion report focused on precinct-level data.

IBO's report explores B-HEARD as it has been structured until now—a program jointly funded, operated, and staffed by the Fire Department (FDNY) and Health + Hospitals (H+H). IBO conducted its analysis using FDNY data from the beginning of the program in June 2021 through the end of March 2025. Key takeaways from the report include:

Eligibility

- The number of calls deemed eligible for a B-HEARD response increased ninefold between the first full quarter during which the program was operational and quarter three of fiscal year 2025, the last period for which IBO has data.
- While a greater share of calls has been deemed eligible for a B-HEARD response (consistently more than 40% since the third quarter of 2023), a declining share of the eligible calls have been assigned a B-HEARD unit (down from nearly 80% at the beginning of the study period to 37% by the end).

Response Time and Time Spent on Scene

- IBO's analysis reveals that response times are slowing, not just for calls eligible for and receiving a B-HEARD response, but for mental health calls citywide as well.
- At the beginning of the study period, the median response time for B-HEARD units was 12 minutes while at the end of the period this had grown to 21 minutes.
- In the most recent period of data, the third quarter of 2025, the median response time for non-B-HEARD units was approximately 19 minutes, slightly faster than for B-HEARD units.

- B-HEARD teams typically spend a longer time on site than other teams responding to mental health calls, indicating that they are taking longer to evaluate and resolve the cases once contact is made. In the most recent data on hand, the median time spent on scene for calls receiving a non-B-HEARD response was 19 minutes. For calls receiving a B-HEARD response, the median time spent on scene was 33 minutes.

Staffing

- As the area covered by the program has expanded, the number of teams has also grown, though not at the same scale. B-HEARD began operation in 2021 with two teams per shift, expanding to three teams by the end of 2022, and then six by the end of 2023. By the end of 2024, with 31 precincts covered by the program, there were nine teams operating during each shift. That was also true in 2025.

As the City moves toward developing its Department of Community Safety, this research provides unique insight into mental health calls, B-HEARD teams, the timing of B-HEARD responses, and geographies served. Additionally, as there have been calls by Council Members and advocates to expand the program citywide, and to also extend the hours of operation to 24 hours a day, IBO's report identifies operational challenges that must be considered. B-HEARD is still considered a pilot though it has been operating for more than four years and currently serves 31 of the 78 police precincts, approximately 40% of the New York City population. As the program has expanded, response times have slowed. This may be in part attributable to the program's expansions outpacing the scaling of its staff.

Looking ahead, if the City chooses to proceed with the current program model, officials might consider what staffing levels are optimal in order to meet current demand levels in terms of the volume of mental health calls received. If the City moves forward with the Adams administration's proposal to shift B-HEARD to H+H's sole control, factors such as call routing without FDNY involvement, replacement of FDNY's staffing, and contracting for emergency vehicles are all issues that will provide operational challenges if not addressed.

Thank you for the opportunity to testify and I am happy to answer any questions.

To see more of IBO's work and to follow IBO on socials scan here: SCAN ME

IBO EXPLAINS February 2026

New York City Independent Budget Office

Director Louisa Chafee

The Behavioral Health Emergency Assistance Response Division (B-HEARD)

Hello Council Member,

In addition to testimony, the Independent Budget Office is providing this summary of findings from IBO's recent reports "From Dispatch to Doorstep: Tracking B-HEARD's Response to Mental Health Crises" and "B-HEARD: A Look at Precinct Level Data"

The QR code on the right provides a link to both reports.

The Behavioral Health Emergency Assistance Response Division (B-HEARD) is New York City's program for non-police response to emergency mental health crises. IBO has recently published a report that explains how the program has been structured and coordinated to date to highlight key operational trends that may inform future decisions. IBO's report is not an audit and does not evaluate the specific goals of the program or its effectiveness in meeting them, nor does it analyze or discuss health outcomes for individuals served by the program. Instead, IBO focuses on operational questions, particularly analyzing driving factors behind **response time and time spent on scene.** This report aims to help City officials and community stakeholders understand some of the constraints affecting the program and what considerations the Mamdani administration has to weigh going forward.

What is B-HEARD?

B-HEARD is a New York City pilot program meant to respond to certain mental health emergencies with trained behavioral health professionals rather than police officers, and to connect individuals with community-based care when possible. B-HEARD launched in June 2021 in Harlem due to the high volume of mental health calls historically received there. The program has expanded six times since then and appears to be based on geographic proximity rather than purely based on need. It is currently jointly operated by New York City Health and Hospitals (H+H) and the Fire Department of New York (FDNY) with oversight from the Mayor's Office of Community Mental Health (OCMH). H+H supplies licensed social workers, while FDNY supplies emergency medical technicians (EMTs), supervisory staff, and emergency response vehicles.

Where and When Does B-HEARD Operate?

Despite multiple expansions (see: Figure 1), B-HEARD continues as a **pilot**, indicating that the City considers its operations and logistics still under evaluation. As of the most recent expansion in October 2023, B-HEARD operates in **31 of New York City's 78 police precincts**, covering approximately 40% of the city's population. The pilot area includes:

- All of the Bronx
- Upper Manhattan
- Central Brooklyn
- Northwestern Queens

As of the end of 2025:

B-HEARD operates between the hours of 9:00 AM and 1:00 AM every day.

- There are nine B-HEARD teams during each 8-hour shift responsible for covering the entire pilot area.
- Total staffing includes 38 H+H social workers and 58 FDNY staff, including EMTs and supervisory personnel. B-HEARD teams consist of three people, two FDNY EMTs and one licensed H+H social worker.
- The program's budget is $35 million, up from $26 million in its first full year (2022). That 35% increase in budget occurred alongside a ninefold increase in the number of precincts that are covered.

How Does B-HEARD Operate?

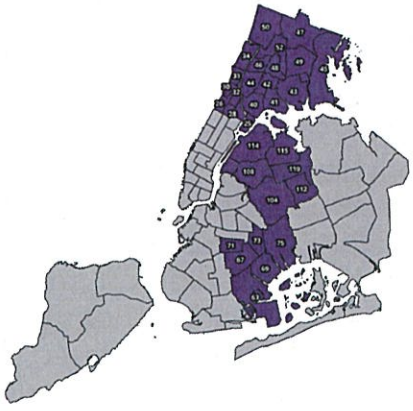
When a person calls 911 to report a mental health emergency, the call is first handled through the NYPD's 911 system. If the call originates from a precinct covered by B-HEARD and occurs during B-HEARD's operating hours, the call is routed to an FDNY EMS dispatcher for further triage. If there is an EMS dispatcher available to answer, then they determine eligibility for B-HEARD. To be eligible, the caller must confirm that there is no known weapon and that the individual is not an imminent danger to themselves or others.

If a call is deemed eligible *and* if a B-HEARD unit is available, then that unit is dispatched. If no B-HEARD

FIGURE 1

Map of B-HEARD Expansion Over Time

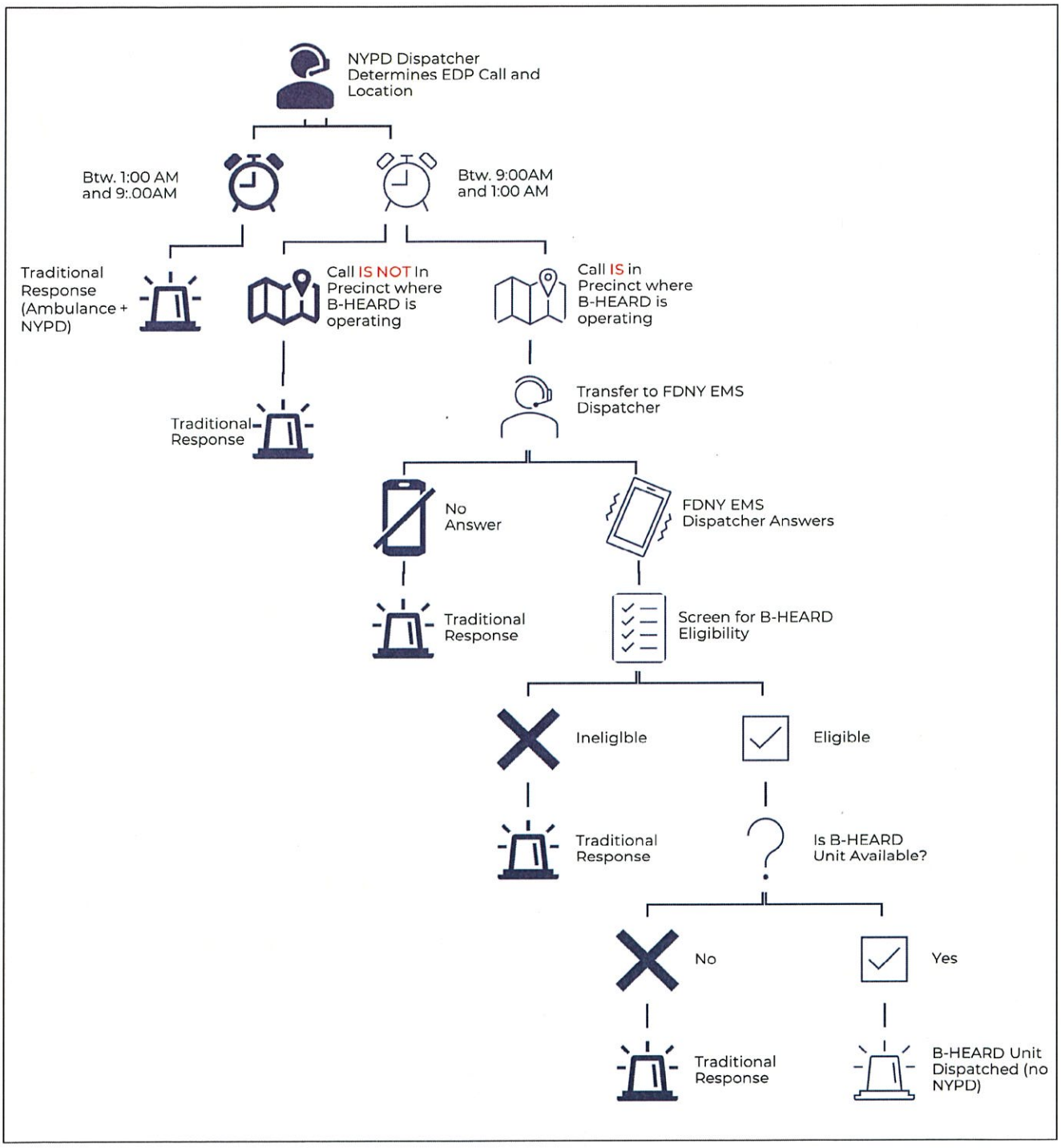
Click map to see a timelapse GIF.



IBO analysis of OCMH B-HEARD webpage and census data
New York City Independent Budget Office

FIGURE 2

Flowchart of B-HEARD Process



SOURCE: IBO analysis of FDNY procedures

New York City Independent Budget Office

unit is available, the call receives a traditional response, consisting of a regular ambulance along with NYPD officers.

For a visual on how this process works, please see IBO's flowchart of the B-HEARD process.

What do the Data Say?

IBO analyzed B-HEARD to better understand how the program functions operationally and to examine trends in response times across multiple program expansions. Especially as EMS response times are rising for all call types citywide, it is essential to understand EDP calls within the broader landscape.

IBO found that across the city, **response times for EDP calls have increased substantially over time**, even as the number of calls has declined. From the first quarter of 2022 through the third quarter of 2025:

- The average response time for EDP calls more than doubled, increasing from about 12 minutes to more than 26 minutes.
- The median response time increased from just over 10 minutes to nearly 16 minutes.

These trends are true of both mental health calls that receive a B-HEARD response as well as calls that receive a traditional police and EMS response.

IBO also found that **B-HEARD teams spend more time on scene** than traditional response teams. In the most recent quarter analyzed, the median time spent on scene was 33 minutes for B-HEARD responses, compared with 19 minutes for non-B-HEARD responses. While this report does not assess outcomes or effectiveness, longer time spent on scene and interfacing with the patient could be indicative of those calls receiving more tailored and appropriate care. Although to truly determine this, the City must evaluate outcomes for patients.

Why is B-HEARD Not Working as Well as it Could?

IBO's analysis points to several interconnected operational factors driving response time trends. As B-HEARD expanded geographically, response times slowed as coverage grew faster than team capacity. With only nine teams per shift serving a large, multi-borough area, units must travel farther and are less likely to be immediately available when a call comes in, especially if they are spending more time on scene. B-HEARD responses are constrained by many factors including the number of teams available at any given time.

Mental health calls are assigned a low response priority within the EMS system, which may further delay dispatch. Moreover, even as the number of calls deemed eligible for B-HEARD has increased nine-fold since the pilot began, a declining share of eligible calls are assigned a B-HEARD unit. In the most recent quarter analyzed, only 37% of eligible calls were assigned a B-HEARD unit, and only 33% ultimately received a B-HEARD response. IBO's full report has more details about this.

What Questions Still Need to be Answered?

Looking ahead, IBO's report highlights several unresolved questions:

- What are patient outcomes and is the current B-HEARD model appropriate and optimal for achieving positive outcomes?
- Will B-HEARD expand to additional precincts or operate beyond its current hours? Before expansion is considered, the City should conduct an evaluation of outcomes.
- What staffing levels would be required to better meet current demand, or increased demand if the program expands further?
- Will the program continue to be jointly operated by FDNY and H+H, transition to sole operation by H+H as previously proposed, or be incorporated into a new Department of Community Safety?
- How will call routing, EMS staffing, and emergency vehicle capacity be handled if FDNY's role changes?

IBO also has analyzed mental health call volume by precinct in a short companion report that can help inform future discussions about where expansion may be most appropriate.

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Serving all five boroughs of NYC

TESTIMONY OF THE ARAB AMERICAN FAMILY SUPPORT CENTER BEFORE THE CITY COUNCIL COMMITTEE ON MENTAL HEALTH AND SUBSTANCE USE
March 4, 2026

Good afternoon, Chair Tiffany Cabán and members of the Committee on Mental Health and Substance Use. My name is Razia Begum, and I am the Mental Health Clinician Supervisor at the Arab American Family Support Center (AAFSC).

AAFSC provides linguistically accessible, trauma-informed, and multi-generational social services to New Yorkers across the city. While our doors are open to all, we have particular expertise in serving the growing Arab, Middle Eastern, North African, Muslim, and South Asian communities. With locations in all five boroughs and services offered in more than 20 languages, AAFSC provides comprehensive, culturally responsive support to more than 20,000 individuals annually.

As members of the Asian American Mental Health Roundtable, we are here to highlight the urgent mental health needs of Asian and immigrant New Yorkers — and the importance of language access, transparency, and accountability within the 911 and 988 systems.

Over the past year, Arab American Family Support Center has experienced a 54% increase in demand for mental health services. Every day, we witness pervasive fear and anxiety in the communities we serve. Families delay seeking critical services. Parents are afraid to send their children to school. Community members avoid medical care and hesitate to report violence or abuse.

Anti-Asian hate, immigration enforcement policies, and ongoing federal uncertainty have significantly heightened distress across our communities. At the same time, stigma, limited English proficiency, and distrust of law enforcement prevent many from seeking help in moments of crisis.

Many Asian and immigrant New Yorkers hesitate to call 911 during a mental health emergency. Language barriers continue to limit meaningful access to crisis support. While we support increased transparency in 911 mental health response data — including tracking B-HEARD dispatches — reporting must include an equity lens to determine whether immigrant and Asian communities are actually receiving health-based responses.

We also support strengthening 988, including the creation of a task force and public education efforts. However, without meaningful community representation, expanded language access, and culturally competent outreach, these reforms will not reach the communities most in need.

At AAFSC, we provide free mental health care in trusted, culturally familiar settings. We also offer domestic violence services, preventive services, housing navigation, immigration legal support, and food distribution. This holistic approach is essential for long-term mental health wellbeing and family stability. Yet sustaining this work is becoming increasingly difficult as demand rises.

We respectfully urge the Council to:

- Include Asian-led and immigrant-serving organizations in the review of 911 data and as members of the 988 task force.
- Invest in community-based organizations that already provide culturally and linguistically competent crisis support.
- Strengthen language access across 988 by hiring multilingual call-takers, expanding Asian language access across text and chat, and partnering with trusted community hotlines.
- Develop equity-centered performance metrics that measure utilization by race, ethnicity, and language — and account for underreporting and barriers to access.
- Fund multilingual public education campaigns delivered through trusted messengers to reduce stigma and raise awareness of 988.

Improving transparency and strengthening 988 are critical steps. But to truly protect the emotional wellbeing of immigrant Asian and immigrant New Yorkers, reforms must center equity, language access, and sustained partnership with community-based organizations.

Thank you for your time and consideration.

Testimony to the New York City Council
Committee on Mental Health & Substance Use
March 4, 2026

Thank you, Chair Tiffany L. Cabán, and members of the Committee on Mental Health & Substance Use, for holding this hearing and providing us with the opportunity to testify. My name is Sofina Tanni, the Senior Program Coordinator at the Asian American Federation (AAF), where we proudly represent a collective voice of more than 70 member nonprofits serving 1.5 million Asian New Yorkers. We are here today testifying as part of AAF's Asian American Mental Health Roundtable, a coalition of 15 Asian-led, Asian-serving organizations that collaborate to address challenges, create solutions, and share resources to increase access to culturally competent mental healthcare.

Our Roundtable partners continue to report rising mental health issues among Asian New Yorkers, driven by the effects of immigration enforcement policies and ongoing anti-Asian hate. Fear of deportation and surveillance discourages many community members from seeking help in moments of crisis. Ongoing uncertainty around federal policies has heightened anxiety and instability within immigrant communities, making individuals even more hesitant to access mental health services. At the same time, stigma, limited English proficiency, and distrust of law enforcement create additional barriers to engaging with 911 and 988 systems.

While we support transparency in 911 mental health response data, including tracking B-HEARD dispatches, reporting must include an equity lens to assess whether immigrant and Asian communities are equitably receiving health-based responses. We support efforts to increase transparency and accountability around 988, and establishing a task force and launching a public education campaign are important first steps. However, without meaningful community representation, expanded language access, and culturally competent outreach, these reforms may still fall short of reaching the communities most in need.

<u>Transparency Gaps in B-HEARD and 911 Mental Health Responses</u>
Currently, New York City lacks comprehensive and standardized public reporting on mental health-related 911 calls and how those crises are handled. While B-HEARD has been instrumental in providing an alternative to law enforcement responses to mental health crises, existing data does not consistently indicate when B-HEARD was or was not dispatched, why certain eligible calls did not receive program services, or whether critical process steps and follow-ups were conducted in full. Audits from the New York City Comptroller's office have identified these significant gaps in tracking and documentation: between Fiscal Years 2022 and

2024, 911 identified 37,113 calls as eligible for a B-HEARD response, yet 13,042 of those eligible calls (35 percent) failed to receive services, with no reason documented.[1] An additional 14,200 eligible calls occurred overnight when B-HEARD was not operating. More broadly, during this same period, B-HEARD covered 96,291 mental health-related calls during operating hours, but only about 25 percent resulted in an actual B-HEARD response. Even among eligible calls, over one-third did not receive a response, and critical steps, such as assessments and follow-up referrals, were often incomplete or undocumented. These gaps make it difficult to evaluate whether the program is functioning as intended.

These reporting gaps are especially concerning for Asian New Yorkers. There are 1.5 million Asian New Yorkers, with 71% being foreign-born, and 48% of Asian New Yorkers and 72% of our seniors having limited English proficiency (LEP).[2,3] B-HEARD does not currently report any demographic breakdown of people served, making it difficult to assess whether the program equitably serves all New Yorkers. Data from the 2024 988 Suicide and Crisis Lifeline Legislative Report from the New York State Office of Mental Health found that only 0.7% of individuals who disclosed their race identified as Asian, suggesting significant underutilization of crisis services in this community.[4] Given the documented language barriers, cultural stigma surrounding mental health, and fear of law enforcement or immigration consequences, it is critical to understand how Asian New Yorkers are interacting with the B-HEARD crisis system. The City also reports that 86% of 911 mental health calls are routed to the NYPD despite efforts to expand B-HEARD[5].

Although the NYPD and FDNY do publish 911 data, the lack of standardized computer-aided dispatch identifiers limits transparency.[6] Without consistent reporting and clearer data publication, it is impossible to determine whether Asian New Yorkers are equitably utilizing and

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[1] Office of the New York City Comptroller Brad Lander. https://comptroller.nyc.gov/newsroom/new-audit-comptroller-finds-over-a-third-of-eligible-mental-health-calls-did-not-get-a-b-heard-team-response-for-untracked-reasons/

[2] *Asian American growth reshapes city council districts across NYC.* (2025, May 16). The South Asian Times. https://www.thesouthasiantimes.info/do-not-miss/news/asian-american-growth-reshapes-city-council-districts-across-nyc/4248

[3] Asian American Federation. (2016). *Asian American seniors in New York City: An updated snapshot* (Report). https://aafederation.org/doc/Fina_Senior_Report_3.pdf

[4]The 988 Suicide and Crisis Lifeline Legislative Report for New York State. https://omh.ny.gov/omhweb/statistics/988suicideandcrisislifelinereport.pdf

[5] Smith, G. B., & Hogan, G. (2026, February 13). Queens DA Charges Mentally-Ill Man Shot by NYPD, Despite Mayor Mamdani's Wishes. THE CITY - NYC News. https://www.thecity.nyc/2026/02/13/jabez-chakraborty-charged-melinda-katz-zohran-mamdani/

[6]B-HEARD Data - Mayor's Office of Community Mental Health. (2024, September 24). https://mentalhealth.cityofnewyork.us/bheard-data

receiving B-HEARD services. However, our Asian American Mental Health Roundtable partners have also shared that there has been no outreach for the communities they serve, and Asian communities across the city do not utilize 988 or B-Heard. Transparency is essential to ensure that New Yorkers can understand how mental health emergencies are being handled in their city, and so that policymakers can assess whether this crisis response system is being effectively implemented.

Addressing Barriers to 988 Services

Improvements to the 988 crisis system are urgently needed, particularly for Asian communities, as they face heightened mental health issues due to the impact of anti-immigrant policies issued by the federal administration and an increasing surge in anti-Asian hate. The fear of deportation and violence is so great that many Asian Americans choose to forego emergency services. Despite these growing needs, there has been little targeted outreach to these communities, and many remain unaware or wary of resources like 988. The 2024 988 Suicide and Crisis Lifeline Legislative Report from the New York State Office of Mental Health found that only 0.7% of individuals who disclosed their race identified as Asian, in contrast to 6.2% who identified as White and 1.5% each who identified as Black and Hispanic. 88.5% of users did not report their race, revealing a striking disparity between the usage rates of White individuals and other minority groups compared to the minimal representation of Asian users.[7]

This disparity highlights the urgent need for inclusive public awareness campaigns for the Asian community, along with linguistically and culturally competent services and training. While the 988 talk feature can interpret over 200 languages through Language Line Solutions, the chat and text options are limited to English and Spanish, potentially excluding non-English-proficient Asian individuals from accessing support. Additionally, community members have reported difficulty accessing Language Line, long wait times, and communication breakdowns during interpretation. Almost half of our Asian American population in New York remains shut out from crisis support services, deepening existing barriers in mental healthcare accessibility.

The recent case of Jabez Chakraborty illustrates how gaps in both the 988 and 911 systems continue to fail our communities. After his family sought help through 988 during a mental health crisis, the response was delayed and limited, raising concerns about whether responders were adequately trained in culturally competent and trauma-informed crisis intervention. When the situation escalated and police became involved, the encounter ended in violence, highlighting the broader issue that law enforcement officers are often not equipped to respond to mental

[7]The 988 Suicide and Crisis Lifeline Legislative Report for New York State. https://omh.ny.gov/omhweb/statistics/988suicideandcrisislifelinereport.pdf

health emergencies. In the past decade, 24 individuals experiencing mental health crises have been shot or tased to death by the NYPD, underscoring the urgent need to strengthen crisis response systems, so that families seeking help receive appropriate mental health care rather than law enforcement intervention[8]. While families are encouraged to call 988, the system seems underequipped to adequately address mental health emergencies, leading to tragic consequences, such as in the case of the Chakraborty family.

By establishing a task force to evaluate the crisis system and by requiring a culturally and linguistically competent public education campaign, this bill would help ensure that 988 truly serves all communities equitably. Without these reforms, Asian New Yorkers remain effectively shut out of crisis support services.

RECOMMENDATIONS

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

1. Consult directly with Asian-led and immigrant-serving organizations when reviewing and interpreting 911 reporting data.
    a. These organizations are already on the ground providing crisis support and navigating language and trust barriers. Their insights can ensure reporting data reflects lived community realities, not just system-level metrics.
2. Include Asian-led and immigrant-serving CBOs as members of the 988 task force to ensure that recommendations reflect the lived realities of underserved communities.
3. Invest in CBOs that provide culturally and linguistically competent services to the Asian American community in New York City to expand their capacity to deliver crisis and emergency mental health services.
    a. These CBOs already provide trusted crisis support, but lack adequate funding to meet the increased demand for services.
4. Acknowledge and address underreporting and underutilization by marginalized communities when evaluating system success, rather than interpreting low usage as low need.
5. Strengthen language access across all 988 platforms and build partnerships with trusted community hotlines.
    a. Hire call-takers and responders who speak Asian languages, rather than relying primarily on third-party interpretation services.
    b. Expand the number of Asian languages available through chat and text functions.

[8]CCIT-NYC: See Their Faces. Say Their Names. - New York Lawyers for the Public Interest. (2026, February 6). New York Lawyers for the Public Interest. https://www.nylpi.org/resource/ccit-nyc-see-their-faces-say-their-names/

   c. Establish partnerships with community-based crisis hotlines to create smoother hand-offs and referral pathways, recognizing that community members are more likely to call trusted local organizations than a citywide number.
   d. Provide culturally competent and trauma-informed training for interpreters and staff working within the 988 system.
   e. Offer mental health support and resources to interpreters to address vicarious trauma incurred through crisis response work.
6. Develop equity-centered performance metrics that go beyond call volume and response time, and make these findings publicly and widely accessible each year, including:
   a. Utilization rates by race, ethnicity, and language.
   b. Barriers to access among limited-English-proficient communities.
   c. Community trust and satisfaction.
   d. Outcomes beyond immediate crisis stabilization.
7. Fund multilingual, culturally responsive public education campaigns.
   a. Launch city-funded campaigns that highlight 988 in Asian languages and through trusted community messengers, including ethnic media, faith institutions, and grassroots organizations, like our Roundtable.
   b. Ensure messaging reflects the diversity of Asian communities and addresses stigma around mental health.

CONCLUSION

We must do more to protect the emotional well-being and stability of immigrant Asian New Yorkers, particularly as our communities continue to navigate fear, stigma, and barriers to accessing crisis support. Strengthening B-HEARD and 911 transparency, and improving the 988 system, are important steps, but these reforms must center on equity, language access, and meaningful partnerships with community-based organizations. CBOs have proven expertise in providing culturally and linguistically competent care, yet only with adequate funding, representation, and investment can these systems truly serve our communities. The Asian American Federation, in partnership with our Asian American Mental Health Roundtable, remains committed to advancing culturally responsive mental health care and advocating for the needs of Asian New Yorkers. Thank you for your continued leadership and for the opportunity to testify today.

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TESTIMONY OF:

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BROOKLYN DEFENDER SERVICES

Presented before

The New York City Council

Committee on Mental Health and Substance Use

Oversight Hearing on the From Crisis to Care:

How New York City Connects New Yorkers to Mental Health Services.

March 4, 2026

My name is Danielle Regis, and I am a Senior Supervising Attorney in the Mental Health Representation Team of the Criminal Defense Practice at Brooklyn Defender Services (BDS). BDS is a public defense office whose mission is to provide outstanding representation and advocacy free of cost to people facing loss of freedom, family separation and other serious legal harms by the government. We want to thank the Committee on Mental Health and Substance Use and Chair Caban for the opportunity to testify today about how New York City connects people experiencing mental health crises to care.

For 30 years, BDS has worked, in and out of court, to protect and uphold the rights of individuals and to change laws and systems that perpetuate injustice and inequality. After 29 years of serving Brooklyn, we expanded our criminal defense services to Queens. We represent over 40,000 people each year who are accused of a crime, facing the removal of their children, or deportation. Our staff consists of attorneys, social workers, investigators, paralegals and administrative staff who are experts in their individual fields. BDS also provides a wide range of additional services for our clients, including civil legal advocacy, assistance with the educational needs of our clients or their children, housing and benefits advocacy, as well as immigration advice and representation.

BDS' Mental Health Representation Team consists of specially trained attorneys and social workers who are experts in working with and for people who have been accused of a crime and who are living with serious mental illness or a developmental disability. We are proud of having played an important role in the creation of the Brooklyn Mental Health Court in 2002. The Brooklyn Mental Health Court works with people accused of crimes who have serious and

persistent mental illnesses, linking them to long-term treatment as an alternative to incarceration. BDS continues to collaborate with this court to advocate for its expansion to meet the needs of more people, including people with intellectual disabilities and people who have previous criminal legal system involvement.

Background

This month marks my fifteenth year as a public defender, and I have represented people in Brooklyn's Mental Health Court for approximately eight years. Over the course of my career, many of the people I have represented encountered police when they were in crisis and seeking care or when the absence of available care led to the decompensation of their mental health. Too often, untreated mental illness becomes criminalized simply because the appropriate systems of care were not accessible when they were needed most. In many cases, we see NYPD responding to calls for emergency mental health care. When police respond instead of mental health providers, EMTs, or peer advocates, situations often escalate quickly. Often, people we represent are charged with resisting arrest and assaulting a police officer when they decline transportation to a hospital. In other instances, people in crisis face harassment and violence at the hands of the NYPD.

Multiple people I represent were arrested in the hospital emergency room when they were attempting to access critically needed care. In more than one instance, a person I represent was turned away from multiple psychiatric emergency rooms and became frustrated when a second, third, or fourth hospital was unable to provide treatment. Even when presenting to the emergency department to request crisis treatment, police are called. It is critical that people who seek emergency mental health care in a crisis are met with compassionate and immediate care.

BDS' wraparound model seeks to address the complex circumstances that have brought the people we represent into our office. Our interdisciplinary team provides support to people who may have avoided court involvement if they had access to services sooner; we help people apply for public benefits and supportive housing, refer them to mental health and substance use treatment, and locate beds in respite centers and safe havens. We are committed to providing these critical services to the people who come through our doors but wish our clients had more opportunities to access these important and lifesaving support services *before* they have legal system involvement. We urge the City Council to consider why it most often takes an arrest, criminal investigation, or court involvement for New Yorkers to access the most basic level of mental health assistance.

We are encouraged by the Council's and the Mayor's commitment to ensuring that people in crisis are met with care, not criminalization, including the creation of the Mayor's Office of Community Safety. It has become nearly impossible to divorce conversations about mental health from discussions on public safety and the criminal legal system. The media and public discourse have conflated the two–creating a false narrative which links mental illness to

increased rates of violence. This messaging exacerbates social stigma and reduces public support for policies that create alternatives to incarceration. The previous administration relied upon policing and forced hospitalization to address chronic mental health concerns. Forcibly removing people perceived to be mentally ill to the most restrictive setting is not only inhumane, it is also ineffective in facilitating the goal of engaging people in mental health treatment. Mental health crises must be treated as health issues, not law enforcement matters. People seeking emergency mental health care must be met with compassionate and immediate care to avoid escalation and possibly arrest.

Recommendations

As the Council and the new administration begin to explore new ways to connect New Yorkers in crisis to care, we respectfully offer the following recommendations:

Increase Healthcare Response to Mental Health Emergencies

Calls for emergency care for mental health concerns should be met by healthcare workers, not police. The city has attempted to change the response to serious mental illness (SMI) through piecemeal legislation and pilot programs. In the neighborhoods where B-HEARD teams are being piloted, NYPD officers are still responding to mental health emergencies in most cases. We are encouraged by your acute crisis intervention plan, including the overhaul and expansion of B-HEARD, the creation of a 24/7 Mobile Crisis Team Program, and increased respite capacity. It is critical that the city invests in public health responses to mental health crises and fully staff emergency response teams.

Expand Access to Low-Cost Mental Health and Substance Use Treatment

Many of the people we represent have tried for years to access mental health and substance use treatment, but struggle to find providers who accept their insurance, speak their language, or have the skills needed to treat complex conditions. These clients are often discharged from hospitals without proper follow-up care and lack appropriate resources in their communities. People seeking care remain on waitlists for months or years for Assertive Community Treatment (ACT) teams, supportive housing, psychiatric visits or other care they require. Individuals are routinely discharged from psychiatric hospitalization with nothing more than a referral to first-come-first-serve walk-in mental health care and a list of congregate shelters or are outright denied services for requiring a “higher level of care” or having a co-occurring substance use disorder. Left without viable treatment options, they are funneled into the criminal legal system–policed, arrested, and incarcerated when they should be receiving health care.

For people with co-occurring mental health and substance use treatment needs, there is only one long-term, inpatient treatment facility in New York City that accepts Medicaid. This means many people we represent spend months waiting for an opening–often while incarcerated on Rikers Island–or, if they have “failed” programming in the past, do not qualify for treatment. To

address the real treatment needs of New Yorkers and address the jail population, it is critical that the city incentivize other dual-diagnosis providers to provide care to accept Medicaid or offer expanded low- or no-cost treatment options.

NYC must increase access to safe, permanent, and affordable housing

When unhoused people are trying to survive on the subway or in the shelter system, accessing consistent physical or mental health care is often impossible. For many of the people I represent, connection to stable housing has been lifesaving. Basic stability allows meaningful engagement in care, but access to supportive housing should not depend on criminal legal system involvement. The city has invested in a vast network of social services to meet the needs of New Yorkers. Too often, people do not know about these programs, struggle to complete opaque application processes, or are denied benefits they are entitled to. The Council should work to expand access to housing programs and address the pervasive administration hurdles that make programs like CityFHEPS or supportive housing difficult to access and use.

Fund culturally competent mental health programs to meet the unique needs of New Yorkers

Cultural competency is a major barrier to services for many people we represent. The existing outpatient mental health programs in the city are often not equipped to address the trauma and unique challenges of people who have experienced arrest, incarceration, chronic housing instability, or migration.

We urge the city to invest in mental health services that are designed for people who have experienced hardship, trauma, or detention. These programs must be equipped to meet the needs of people who are newly introduced to mental health care, to create a familiar, nonthreatening therapeutic environment for those who may be hesitant to engage in treatment. Such programs must employ trained clinicians who are fluent in multiple languages, including Spanish, French, Haitian Creole, and commonly spoken indigenous languages of Northern Triangle and South American nations.

Pass a New York City Council Resolution in Support of the NYS Treatment Court Expansion Act

New York City should commit to creating more off ramps from the criminal legal system. The City Council should call on the state legislature to pass and the Governor to sign the Treatment Court Expansion Act (S.4547-Ramos)/A.4869-Forrest).

In 2009, as part of the Rockefeller Drug Law Reforms, New York State passed the Judicial Diversion Program legislation. Under Criminal Procedure Law Article 216 (CPL §216), this legislation created a pathway for a small subset of people with substance use disorders to avoid

prison and potentially have their charges reduced or dismissed after engaging in a course of treatment. This treatment is monitored by specialized court parts in every county in New York. Judicial diversion has successfully enabled thousands of individuals to minimize or avoid a criminal record while receiving the benefit of potentially lifesaving substance use treatment.

Judicial diversion has also realized the saving of tax dollars, from both reductions in reoffending and the decreased costs per capita of treatment versus incarceration. Unfortunately, CPL §216 diversion is limited to people with substance use disorders charged with a short list of crimes related to substance use. The current law leaves behind people who do not live with substance use disorders, but experience other mental illnesses, developmental disabilities, or cognitive impairments that can be effectively addressed through treatment.

People living with mental health issues deserve treatment, not jail. Mental health intervention through courts can decrease the jail population and provide people with access to treatment they would not otherwise receive if incarcerated. This has been shown to increase mental health program enrollment and completion of these programs reduces homelessness, psychiatric hospitalizations, and rates of recidivism.[1] New York can become a leader in diverting people with mental health issues out of the criminal legal system and into treatment by passing the Treatment Court Expansion Act.

Conclusion

We are grateful to the Committee on Mental Health and Substance Use for holding this hearing on ways New York City connects New Yorkers to mental health services. The number of people living with or having experienced mental health issues remains alarmingly high, and jails and prisons have become the de facto mental health facilities across New York State. We welcome any opportunity to work with this committee to ensure people living with mental illness receive timely, quality treatment and services.

If you have any questions, please feel free to contact Kathleen McKenna, Senior Policy Social Worker, at kmckenna@bds.org.

[1] Nazisha Dholakia and Daniela Gilbert, What Happens When We Send Mental Health Providers Instead of Police, *Vera Institute of Justice: Think Justice Blog,* 2021, Available online at https://www.vera.org/blog/what- happenswhen-we-send-mental-health-providers-instead-of-police.

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Center for Justice Innovation
New York City Council
Committee on Mental Health and Substance Use
March 4, 2026

Good morning Chair Cabán and esteemed members of the Committee on Mental Health and Substance Use. My name is Ruth O'Sullivan, and I serve as the Senior Director of Clinical Practice for the Center for Justice Innovation (the Center). Thank you for the opportunity to testify.

For over 30 years, we have partnered with residents, service providers, and government agencies to develop practical responses that address the underlying causes of justice system involvement and strengthen community well-being across both our community and court-based programs. Central to this work is the belief that access to timely, compassionate mental health care is essential to both individual stability and public safety.

Too often, untreated mental health needs become visible only in moments of crisis, when individuals encounter emergency services, hospitals, or the criminal justice system. When care is inaccessible or fragmented, the systems designed to respond to public safety concerns are left managing complex health needs they are not equipped to address. As a result, jails, courts, and law enforcement have increasingly become the default responders to mental health crises, despite lacking the resources and clinical infrastructure necessary to support long-term recovery and stability.

Our experience shows that when people are connected to appropriate care early—before or immediately following system involvement—outcomes improve for individuals and communities alike. Access to mental health treatment, substance use services, housing support, and other stabilizing resources can reduce cycles of crisis, prevent deeper justice system involvement, and help people live safely and successfully in their communities. Effective public safety strategies therefore depend not only on crisis response, but on strong pathways that connect individuals to ongoing care.

At the same time, significant challenges remain. Many New Yorkers continue to face barriers to accessing mental health services, including stigma, fragmented systems, limited continuity of care, and difficulty navigating complex service networks. Without sustained engagement and clear pathways to treatment, individuals may cycle repeatedly through crisis systems without achieving stability, placing strain on emergency services while leaving underlying needs unmet.

Supporting mental health is fundamentally about promoting dignity, stability, and community safety. When individuals have access to care that addresses trauma, stress, addiction, and serious mental illness, communities benefit from reduced harm, stronger social connections, and fewer preventable crises. Moving from crisis to care requires coordination across systems and sustained investment in approaches that prioritize health-centered responses.

The Center for Justice Innovation's programs are designed to help bridge these gaps by connecting individuals to services, strengthening community-based responses, and supporting pathways away from crisis and toward stability. Below are several examples of our work that demonstrate how connecting New Yorkers to care can improve both individual outcomes and public safety.

Brooklyn Mental Health Court

The Brooklyn Mental Health Court (BMHC), based within Brooklyn Supreme Court, was New York City's first mental health court and has served as a local and national model for over twenty years. BMHC crafts effective responses to crime committed by people suffering from severe mental illness, including those facing felony charges. In addressing both participants' treatment needs and community public safety concerns, the court links defendants with serious and persistent mental illness—who would ordinarily be jail- or prison-bound—to long-term, community-based treatment as an alternative to incarceration. Cases are referred by judges, defense attorneys, and the Kings County District Attorney's office.

Given the wide range of challenges participants in our mental health courts often face, being able to administer critical treatment services while helping them remain stably connected to their community is of vital importance. Through 2025, over 1,500 participants have received treatment, satisfied program requirements, and graduated, all while avoiding the harms of incarceration.[1] Active participants boast a 74 percent compliance rate while in Brooklyn Mental Health Court. These participants have a reduced likelihood of a rearrest and a 17 percent reduction in the likelihood of a re-conviction compared to a comparison group.[2] This data shows that the program is not just effective at administering treatment but also at improving public safety, features traditional incarceration often lacks. As evidenced by the reduction in re-arrests and convictions, these programs address the problems that result in justice system involvement and benefit individuals and communities for years to come while saving the city from increased incarceration costs.

Manhattan Misdemeanor Mental Health Court

The Manhattan Misdemeanor Mental Health Court (MMHC) helps people with mental health issues and co-occurring disorders engage meaningfully in social services that aim to reduce their involvement in the justice system. The program combines clinical assessment, collaborative case planning among legal and social service partners, and trauma-informed engagement to address underlying behavioral health needs while promoting community safety.

Participants receive comprehensive support, including connections to mental health and substance use treatment, benefits, housing assistance, and community-based services. Cases typically reach resolution within 33 to 44 days, allowing individuals to stabilize more quickly and move forward without prolonged court involvement.

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[1] Center for Justice Innovation. (2025). Brooklyn Mental Health Court Database. [Data file].

[2] Rossman, S.B., J. Buck Willison, K. Mallik Kane, K. Kim, S. Debus-Sherrill & P.M. Downey (2012, July). Criminal Justice Interventions for Offenders with Mental Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn, New York. New York, NY: Urban Institute. https://www.urban.org/sites/default/files/publication/25576/412603-Criminal-Justice-Interventions-for-Offenders-With-Mental-Illness-Evaluation-of-Mental-Health-Courts-in-Bronx-and-Brooklyn-New-York.PDF

The program has demonstrated strong outcomes. Since launching in 2022 through 2025, MMHC has graduated 616 people.[3] Additionally, the Court's expedited case resolutions allow clients to move forward with their lives. This saves the criminal justice system and its actors valuable resources while supporting a positive, restorative outcome for the client. The Midtown Community Justice Center team, which helps operate the Misdemeanor Mental Health Court, aims to make the most of the short time participants have in the program by linking them to ongoing mental health and substance use services, benefits, and housing support, as well as by helping to strengthen their relationships with family, friends and supportive networks. Many participants elect to continue with voluntary services even after the completion of a mandate.

Community First

The Midtown Community Justice Center's Community First program serves community members experiencing varying levels of housing insecurity and homelessness in the Times Square area. The program also serves participants facing housing insecurity from across the Midtown Community Justice Center's programs, including the Manhattan Misdemeanor Mental Health Court, Emerging Adult Court, Arraignment Part (AP6), and Project Reset. While New York City is service-rich, the field often operates in silos, creating a disjointed system of care for the most vulnerable populations. Often, those who need support live under the radar until a moment of crisis like an arrest or an emergency room visit forces a response. As a pre-crisis intervention, Community First seeks to facilitate continuity of destigmatizing and client-centered care for some of the city's most disconnected residents through mobile case management, street outreach, and assistance for court-involved and diversion participants.

Community First's Community Navigators share lived experience with participants, offering peer support to help clients achieve self-identified goals such as obtaining transitional or permanent housing, substance use treatment, mental and physical health care, identification, financial benefits, employment, and legal assistance. The model differs from existing street outreach initiatives by focusing on building trusting relationships and meeting community members "where they're at" before making linkages to longer-term services provided by community-based organizations in the Midtown Community Justice Center's network. The time spent building trust with community members in need results in those individuals confidently engaging in critical services with greater chances for long-term success. Since launching in 2021, the Community Navigator team has engaged 1,649 individuals in more than 5,064interactions through the end of 2025.[4]

Bronx HOPE

Bronx Heroin Overdose Prevention and Education (HOPE), an initiative of Bronx Community Solutions, addresses substance use issues with a harm reduction model at the precinct level. By giving clients the option of accessing community services instead of appearing in court, Bronx HOPE gives residents in the Bronx the opportunity for rehabilitation and connection to community rather than jail and punitive responses that fail to address the underlying issues.

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[3] Center for Justice Innovation. (2025). Justice Center Application database. [Data file].
[4] Center for Justice Innovation. (2025). Justice Center Application database. [Data file].

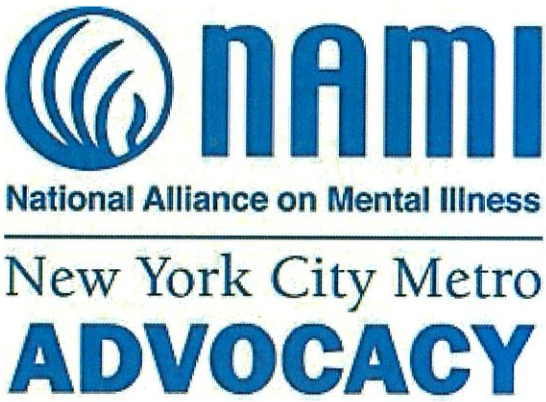
Eligible individuals issued Desk Appearance Tickets are met at the precinct by peer mentors with lived experience, who provide overdose prevention education, distribute Naloxone, and connect individuals to case management support. Within seven days, participants are connected with a Bronx HOPE case manager. Clients then work with case managers to complete assessments, develop individualized service plans, and access treatment and supportive services tailored to their needs. Case managers also provide ongoing support in the completion of services.

Bronx HOPE demonstrates that people with eligible cases are more likely to engage in programming when peer mentors are present at the precinct. In 2025, Bronx HOPE had a contact rate of 89 percent for dispatched cases. Of those cases that were dispatched and began programming, 86 percent completed their services, thereby preventing the need for participants to appear in court and face criminal charges.[5]

Conclusion

Thank you for your leadership and for the opportunity to testify today. We look forward to continuing to work in partnership with the Council to strengthen pathways to care and promote safer, healthier communities for all New Yorkers.

[5] Center for Justice Innovation. (2024). Reset/Hope referral database. [Data file].



New York City Council Oversight Hearing "From Crisis to Care: How New York City Connects New Yorkers to Mental Health Services."

before the

Committee on Mental Health and Substance Use

on

Wednesday, March 4th at 10:00am

Testimony By: Jonathan Chung, MPA (he/him)
Director of Public Policy and Advocacy
National Alliance on Mental Illness of New York City (NAMI-NYC)

INTRODUCTION

Good morning, Chair Caban, and Members of the Committee. My name is Jonathan Chung, and I am testifying on behalf of the National Alliance on Mental Illness of New York City (NAMI-NYC), which is the *only* nonprofit in the city providing free, direct, and extensive peer *and* family support services to New Yorkers caring for someone living with serious mental illness. I also serve as a Steering Committee member of the Correct Crisis Intervention Today of NYC (CCIT-NYC). Thank you for holding this important oversight hearing.

OUR WORK

NAMI-NYC is one of the largest affiliates of the National Alliance on Mental Illness, the nation's leading grassroots mental health advocacy organization. For more than 40 years, NAMI-NYC has been a voice for the mental health community across the city. We provide advocacy, education, and peer-led support services to individuals living with mental illness, their families, and the broader public, all completely free-of-charge. Our programs are led both for and by those directly affected by mental illness, and they reflect the diversity of New York City.

SUPPORT FOR INT. 722-2026

Before addressing the topic of today's oversight hearing, I want to affirm NAMI-NYC's support for Intro 722-2026, important legislation aimed at increasing transparency in the city's Behavioral Health Emergency Assistance Response Division (B-HEARD) program. Since its inception in 2021, B-HEARD has been plagued by, among other things, inconsistent reporting, and very limited data available to the public. Int. 722, sponsored by Council Member Schulman, addresses this matter by requiring quarterly reporting and publication of mental health emergency response data from the Office of Community Mental Health. This bill will allow the public and

policymakers to have important, consistently reported data that is critical to assessing what is working, what is not, and where the city needs to focus in order to have a robust peer-led, behavioral health response to individuals experiencing a mental health crisis. NAMI-NYC urges the Committee and the full Council to support this legislation.

SUPPORT FOR PRECONSIDERED INT.

I want to also affirm NAMI-NYC's support for the Preconsidered Intro being heard today, sponsored by Council Member Lee, which would create a task force to study the current 988 system and make recommendations for its improvement, as well as require the Department of Health and Mental Hygiene (DOHMH) to create a public education campaign on mental illness and raise awareness on 988 and the full range of services available through 988. By connecting people to trained counselors, clinicians, and peers, the 988 Suicide and Crisis Lifeline saves lives. The city needs to do everything necessary to ensure that 988 has all the resources it needs to operate robustly, and that every New Yorker knows about 988 and the critical services they can be connected to such as mobile crisis teams and additional community supports. NAMI-NYC would welcome the opportunity to work with the 988 Task Force and urges the Committee and the full Council to support this legislation.

DECRIMINALIZING MENTAL ILLNESS

New York City has made progress in acknowledging the mental health crisis, but too often our systems still treat mental illness through a criminal justice lens rather than a care-first approach. The city must commit to policies that truly decriminalize mental illness and ensure that New Yorkers in crisis encounter support instead of handcuffs. That starts with creating permanent,

stable funding for the 988 Suicide & Crisis Lifeline. Without reliable funding and staffing, 988 cannot meet its growing demand or connect callers to real-time care options across the city.

At the state level, New York must pass Daniel's Law to establish a statewide crisis response system that sends trained mental health professionals and peers—not law enforcement—to behavioral health emergencies. This should be paired with reforms to strengthen and expand alternatives to incarceration, including greater use of mental health courts and passage of the Treatment Court Expansion Act so more individuals can access rehabilitative care. New York City must also reform its B-HEARD program to create a peer-led, non-police crisis response model that is transparent, available citywide and at any time of the day, and reflects best practices as outlined by the NYC Correct Crisis Intervention Today coalition.

Equally important is building the infrastructure that allows people to receive care instead of cycling through emergency rooms and jails. The city should significantly increase the number of Crisis Stabilization Centers and Crisis Respite Centers so individuals have immediate, short-term places to go during psychiatric emergencies. At the same time, funding for Intensive Mobile Treatment teams, Assertive Community Treatment teams and Mobile Crisis teams must be expanded so that clinicians and peers can reach people where they are in the community.

Finally, decriminalizing mental illness requires confronting the reality that jails have become the largest mental health institutions in the country. New York City must recommit to closing Rikers Island and replacing it with a borough-based system that is able to provide incarcerated individuals living with serious mental illness the treatment they need. If we invest in proper crisis response, treatment infrastructure, and community-driven solutions, we can finally shift from a system of punishment to one of healing and support.

ACCESSING CARE

It is not enough to simply connect people to services. We must ensure those services are accessible, culturally competent, and delivered by providers who are not overwhelmed by impossible caseloads. And we need to ensure that people have housing. That begins with adopting a true Housing First model, grounded in the evidence that stable housing is the foundation for recovery and long-term mental health stability. Without housing, treatment plans are difficult to adhere to and individuals often times are pushed back into punitive systems. By prioritizing permanent supportive housing and removing barriers to access, the city can help people stabilize while also easing the strain on emergency services.

At the same time, we must invest in the behavioral health workforce that makes care possible. Salaries for mental health professionals, case managers, and peer specialists must be increased so that providers can recruit and retain skilled individuals. New York should also pass the Social Work Workforce Act, which would strengthen and expand the pipeline of social workers entering the field, and the Mental Health Educational & Higher Educational Opportunity Program Act, which would incentivize students from diverse backgrounds to pursue careers in the mental health field. These are some of the steps that can be taken to build a workforce that reflects the communities it serves and is equipped to deliver culturally competent care.

The city and state must also address systemic gaps that undermine the continuity of care. Reforming hospital discharge planning is critical to ensuring that individuals leaving psychiatric or emergency settings are connected to stable housing, shelters, outpatient treatment, and community supports—not discharged into homelessness and/or with no treatment plan in place.

For our young people, expanding the number of school-based mental health clinics to all New York City schools is particularly important, because we must reduce every single barrier possible for them, so they feel safe and supported. Suicide is the second leading cause of death for middle and high school students. We must do better to support them.

Finally, insurance barriers must be addressed so that people can actually receive the treatment that clinicians recommend. Passing Anti-Fail First insurance legislation, for example, would prevent insurers from forcing patients to try ineffective treatments before accessing the care and medicines they actually need. Taken together—housing stability, workforce development and investment, culturally competent providers, improved discharge planning, and fair insurance coverage—these policies will help to ensure that when New Yorkers reach out for help, they are connected to care that is timely, effective, and truly responsive to their needs.

CONCLUSION

In closing, while taking these steps would represent meaningful progress; they are still only part of what is required for New York City to meaningfully connect people to proper care. Decriminalizing mental illness and building a system that works for everyone will require sustained commitment, coordination, and investment. There are many additional opportunities to strengthen the continuum of care such as, expanding prevention and early intervention programs, strengthening community-based services, supporting families and caregivers, and ensuring that people with lived experience help shape policy solutions. If we align our policies, funding, and workforce around dignity, access, and the full continuum of care, we can create a system that not only responds to crisis but does its best to prevent it. Moreover, we can ensure every New Yorker has a real pathway to healing, stability, and recovery.

Thank you, Chair Caban, for the opportunity to testify today. We at NAMI-NYC appreciate your leadership on this critical issue and stand ready to serve as a resource to you, Speaker Menin and the City Council.

Sincerely,

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Testimony of

Carly Shapiro, LMSW, MPH

Forensic Social Worker

New York County Defender Services

Before the

Committee on Mental Health

From Crisis to Care: How New York City Connects New Yorkers to Mental Health Services.

March 4, 2026

My name is Carly Shapiro and I am a Forensic Social Worker at New York County Defender Services (NYCDS). NYCDS is an indigent defense office that every year represents tens of thousands of New Yorkers in Manhattan's Criminal, Family, and Supreme Courts. Thank you to Chair Cabán for holding today's hearing and to all of the Council Members who have sponsored the bills on today's agenda that seek to bring more transparency to our City's behavioral health system. In addition to a Masters in Social Work, I also possess a Masters in Public Health.

I. Background:

For the people we serve, timely access to mental health and substance use treatment can be the difference between incarceration and stability in the community.

We have specialized expertise serving justice-impacted New Yorkers living with serious mental health challenges. Many of our clients face untreated mental illness, co-occurring substance use disorders, and complex trauma histories. Our forensic social work units are central to this work. These licensed professionals are trained in trauma-informed care, substance use disorders,

serious mental illness, and family systems. Working closely with our attorneys, they address the emotional, clinical, and social needs of our clients, helping them navigate public systems, access treatment, secure housing, and obtain alternatives to incarceration. This approach improves both legal outcomes and long-term well-being.

Our Re-Entry Unit focuses on stabilizing individuals before release from facilities including Rikers Island and sustaining that stability once they return home. We coordinate behavioral health appointments, ensure medication continuity, connect clients to housing and benefits, provide warm handoffs to community providers, and advocate during parole hearings. Nearly half of individuals with serious mental illness return to Rikers after release. By connecting clients to consistent, community-based behavioral health care and providing intensive re-entry support, our unit interrupts this cycle, reduces recidivism, and promotes public safety.

Through our work, we have identified systemic barriers that prevent timely access to care. The Single Point of Access (SPOA) system is severely backlogged and opaque, leaving people waiting indefinitely for critical services. Emergency Transitional Housing lacks a central application system, forcing clients and providers to navigate a confusing patchwork. Across behavioral health services, New York City needs more investment, greater transparency, and simplified access to ensure that people can get the care they need when they need it.

Mental health has been criminalized for decades. Problem-solving courts offer alternatives to incarceration, but access is inconsistent. The City should call on the State to enact the Treatment Court Expansion Act (S4547/A4869) to establish mental health courts in every county and modernize problem-solving courts so that people with mental health challenges are diverted from the criminal legal system and into treatment.

Connecting New Yorkers to behavioral health care requires coordinated systems, timely access, and meaningful diversion from incarceration. NYCDS is ready to partner with the City to improve SPOA, centralize transitional housing applications, increase investments, and expand treatment courts. These reforms are not abstract policy changes. They are life-changing interventions that promote stability, dignity, and public safety.

1. **<u>Navigating a Broken System: Incremental Fixes in the Face of Structural Failure</u>**

On-the-Ground Observations and Recommendations

Our social workers encounter barriers at nearly every stage of connecting justice-impacted New Yorkers to mental health and related services, be it during referral, placement, or follow-through. The obstacles are numerous and well-documented by others in this space. We focus here on two specific areas—access to Single Point of Access (SPOA)-connected services, and emergency and

transitional housing placement—not because they are the only problems, but because they are areas where we can identify concrete, implementable solutions. Where a clear fix exists, there is no justification for delay.

Reforming Access to SPOA Services

SPOA, the Single Point of Access program administered by the NYC Department of Health and Mental Hygiene, is the primary gateway to high-intensity community-based mental health services. Referrals move from a basic wellness coordination tier, through Assertive Community Treatment teams providing intensive 24/7 support for people with severe and persistent mental illness, up to Intensive Mobile Treatment units serving those with the most acute mental health needs, housing instability, or recent criminal justice involvement. This continuum, when functioning, is exactly what our clients need.

SPOA is not functioning as intended. It is severely backlogged, and in the pretrial context, such backlogs have immediate, measurable consequences. Whenever public defenders like our office include SPOA-connected services as part of an alternative-to-incarceration plan for the timely release of incarcerated clients, a judge must be satisfied that those services will materialize. Without any ability to confirm a timeline, judges decline to release our clients who remain detained, losing jobs, losing housing, losing the social ties that are foundational to recovery, while waiting for services that may be days or months away. No one can tell us which. The waitlist is not just long; it is opaque.

The City Council should work with the NYC Department of Health and Mental Hygiene to establish a HIPAA-compliant system allowing providers to track where a referred client stands in the queue. A secure portal where a case worker can enter a unique client identifier and retrieve an estimated connection date would be sufficient. A dedicated liaison hotline staffed to communicate timelines to providers would also work. Either would be a significant improvement over the current situation, in which our social workers and attorneys are making consequential decisions without basic information.

Establishing a Centralized Portal for Emergency Transitional Housing

MOCJ's Emergency Transitional Housing program, offering stays of six to twelve months across all five boroughs through a nonprofit network and now operating at 850 beds, is a meaningful resource for justice-impacted New Yorkers returning home. This began in 2020 as the pandemic created issues of overcrowding within the facility. It is a lifeline for residents that is transformative for people's lives. As one person described, "It's amazing. You feel you're coming home to something. You're not just going back to the streets. You're not going to jail then back to, 'I gotta do what I need to do to eat.' I have a warm bed."[1]

[1] Annie Grossinger, "*'I Know That I'm Living This Cinderella Life'*," *Curbed* (Dec. 16, 2022), https://www.curbed.com/2022/12/photo-rikers-former-inmates-hotel-emergency-housing.html.

But currently, there is no centralized intake, no publicly available bed availability and vacancy data, and no shared referral system. Every placement requires our staff to contact individual providers from scratch who have different application processes, with no guarantee of a timely or informative response. People fall through the cracks during the most precarious window of their lives not because beds do not exist, but because no one can locate them in time.

This is a solvable problem. As discussed in the previous section, SPOA exists precisely because the healthcare field recognized that fragmented intake creates dangerous delays. MOCJ's ETH operates in direct contradiction to that lesson. The City Council should establish a centralized, real-time portal for ETH housing, a single interface showing current bed availability by borough and provider, and with a single referral form with clear instructions for the application and its submission, and with information about the application screening process. The reduction in staff burden with a centralized referral system would be real and substantial. More importantly, it would prevent avoidable placements from collapsing simply because our team ran out of runway.

Support and Connection Centers, administered by the NYC Department of Health and Mental Hygiene, which can place clients in emergency housing on or before the day of a court appearance, also have no consolidated public-facing information about how many SCC locations exist, which locations are currently operational, how many beds in each location, or what capacity is coming online. A lack of forethought about how practitioners actually use these systems produces failures that may feel minor from a policy distance, but are catastrophic for our clients. Consequently, such repeated systemic failures contribute to intense moral injury and rapid burnout for on-the-ground case workers.

SPOA AND ETH are Not Isolated Examples of Systemic Barriers

Justice Impacted Supportive Housing (JISH) is a crucial lifeline for our clients. Not only does JISH provide critical and timely housing, but also it offers treatment and wraparound services for those cycling between various institutional settings. This housing program not only provides a safe and stable landing for those emerging from incarceration, it stops the cycle of recidivism. Of the people presently living in the JISH units currently up and running in NYC, close to 90% have had no rearrests since JISH placement.[2] Expansion of supportive housing, particularly for those who are justice-impacted, is critical to the City's efforts to close Rikers Island by the legally mandated date.[3]

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[2] NYC Health Department, "*NYC Health Department Releases Updated Request for Proposals to Expand Supportive Housing for Formerly Incarcerated and Homeless New Yorkers*," press release, February 12, 2026, *NYC.gov*, https://www.nyc.gov/site/doh/about/press/pr2026/request-for-proposals-to-expand-supportive-housing.page.

[3] Independent Rikers Commission, *A Path Forward: The Blueprint to Close Rikers Island* (March 2025), https://static1.squarespace.com/static/5b6de4731aef1de914f43628/t/6802a228b5619e3f5bafd0cf/1745003055967/Independent+Rikers+Commission+Blueprint+to+Close+Rikers+Island+March+2025.pdf.

In 2019, as part of its plan to close Rikers, the City increased its commitment of JISH to 500 units, and the City has substantially increased funding and streamlined access in recent years.[4] Unfortunately, most of these units have failed to materialize, and the city currently operates only 120 open JISH beds.[5] Just last month, the City released a request for proposals (RFP) for 190 JISH units. However, there's no clarity on when 190 more units will become available, and when the City hopes to catch up to the City's 500-unit commitment.[6]

The Structural Argument

We offer these recommendations with a precise understanding of what they are: interim measures that would make a broken system somewhat more navigable. They would not fix it.

Decades of disinvestment have produced underfunded, siloed systems in which people are routinely lost in the cracks and repeatedly returned to the criminal legal system. Deinstitutionalization came with a promise of robust community-based care. That promise was not kept, and the resulting debt - in unmet need, in incarceration, in human cost - continues to compound.

What we ultimately need is sustained investment in emergency and transitional housing, and other housing, expanded ACT and FACT teams, and respite centers such as SCCs that provide barrier-free and immediate access to genuine alternatives to emergency rooms and jails. These interventions work. The evidence is not in dispute. What is lacking is funding and political will for a real investment in the people and communities in great need of timely access to quality resources and services.

If this Council is serious about public safety, it must reckon with where the money is currently going. The cost of incarceration at Rikers Island is well documented. The cost of the alternatives, proven, evidence-based, community-rooted, is substantially lower and substantially more effective. The question before this Council is not whether New York City can afford to build these systems. It is whether it can afford not to.

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[4] Jeanmarie Evelly, "*Funding Boost Could Fulfill City's Pledge to Expand Housing for New Yorkers Who Cycle Between Shelter and Jail*," *City Limits*, August 14, 2025, https://citylimits.org/funding-boost-could-fulfill-citys-pledge-to-expand-housing-for-new-yorkers-who-cycle-between-shelter-and-jail/.

[5] NYC Health Department, "*NYC Health Department Releases Updated Request for Proposals to Expand Supportive Housing for Formerly Incarcerated and Homeless New Yorkers*," press release, February 12, 2026, *NYC.gov*, https://www.nyc.gov/site/doh/about/press/pr2026/request-for-proposals-to-expand-supportive-housing.page.

[6] Id.

II. Proposed Legislation:

A. *Int 0722-2026* - a bill that would require quarterly reporting on 911 calls flagged as mental health emergencies.

NYCDS supports this legislation. Int. No. 722 expands transparency and accountability for B-HEARD, the City's behavioral health emergency response program.

B-HEARD deploys teams of first responders and mental health professionals to respond to 911 calls in covered areas, operating sixteen hours a day across an expanded pilot that now covers roughly forty percent of police precincts. This legislation would require quarterly reporting on key program metrics, including whether a B-HEARD team was dispatched and able to respond, response times, and critically, whether the individual experiencing the mental health emergency was left at the scene, subjected to involuntary removal, experienced a use of force incident, was issued a summons, or was arrested.

That last category of data is particularly significant. People with serious mental illness are nearly ten times more likely to experience use of force from police than the general population, a disparity rooted in how officers can misinterpret the symptoms of psychiatric crisis as threatening behavior.[7] What is less understood is how Kendra's Law is being operationalized in practice following its expansion in the FY2026 state budget, which gave police greater authority to involuntarily commit individuals deemed a threat to themselves or others.

This legislation also appears directly responsive to gaps identified in a May 2025 Comptroller's audit, which found that 13,042 people eligible for B-HEARD, representing 35% of eligible calls, did not receive program services. An additional 14,200 eligible calls came in outside the program's hours of operation.[8] The audit emphasized that due to a gap in data collection by the Mayor's Office, the reasons behind these failures remain unknown.

Int. No. 722 addresses this problem directly by requiring reporting on why eligible calls do not result in a B-HEARD response and whether calls resulted in a warm handoff to a treatment provider. A January 2025 Independent Budget Office report also found that average B-HEARD response times have more than doubled, from 12 minutes to over 26 minutes, a trend that

[7] National Alliance on Mental Illness (NAMI), "*Police Use of Force*," *Stopping Harmful Practices – Policy Priorities*, accessed March 4, 2026, https://www.nami.org/Advocacy/Policy-Priorities/Stopping-Harmful-Practices/Police-Use-of-Force/

[8] Office of the New York City Comptroller, *Audit of the Behavioral Health Emergency Assistance Response Division's Effectiveness in Responding to Individuals with Mental Health Crises and Meeting Its Goals*, Audit Report MG24-060A, May 23, 2025, https://comptroller.nyc.gov/reports/audit-of-the-behavioral-health-emergency-assistance-response-divisions-effectiveness-in-responding-to-individuals-with-mental-health-crises-and-meeting-its-goals/

warrants close monitoring and is consistent with capacity constraints seen in comparable models in other jurisdictions.[9]

We want to be clear about how this data should be used. The proof of concept for B-HEARD is well established. The gaps in its service provision are not inherent to the model; they are the direct result of understaffing, insufficient sites, and limited hours of operation. Transparency is necessary and overdue, but data collection should serve as a catalyst for full-scale implementation, not a precondition that delays it further. We have witnessed too many fatalities that result from deploying law enforcement to respond to psychiatric crises for which officers are not trained or equipped. This legislation should mark a step toward expanding B-HEARD to meet the full scope of need, not a pause while we gather the evidence we already have

B. *T2023-3879* - a bill that would create a task force to study the current 988 system and make recommendations for its improvement, and would require the City to create a public education campaign to promote 988.

NYCDS supports this legislation. 988 represents one of the most important shifts in how this country responds to mental health crises, redirecting people away from law enforcement and toward trained behavioral health professionals. But implementation of 988 has yet to reach its laudable promise. This bill takes meaningful steps to close that gap.

Since its national launch in 2022, 988 has faced significant structural obstacles. The most immediate is chronic understaffing, a problem that is not unique to New York but reflects a nationwide crisis in behavioral health workforce development and retention. When calls go unanswered or wait times are too long, people in crisis default back to 911, risking exactly the kind of law enforcement interaction that 988 was designed to prevent. Fortunately, New York does meet the nearly 90% target response rate[10] and this is promising.

The task force established by this bill has the potential to accelerate meaningful reform by drawing on innovations already proven in other states. Some states have created 988 advisory boards with continuous improvement mandates. Others have developed non-law enforcement transportation options to bring callers to treatment without police involvement, and dedicated lines staffed by specialists serving specific populations, such as Indigenous populations[11]. New

[9] New York City Independent Budget Office (IBO), *From Dispatch to Doorstep: Tracking B-HEARD's Response to Mental Health Crises* (January 2026), https://www.ibo.nyc.gov/assets/ibo/downloads/pdf/public-safety/2026/2026-january-from-dispatch-to-door-step.pdf.
[10] New York State Office of Mental Health, *The 988 Suicide and Crisis Lifeline Legislative Report for New York State* (Albany, NY: New York State Office of Mental Health, 2024), https://omh.ny.gov/omhweb/statistics/988suicideandcrisislifelinereport.pdf
[11] Inseparable, *A Better Response: Improving America's Mental Health Crisis System* (June 2024), https://www.inseparable.us/wp-content/uploads/2024/06/Inseparable-2024CrisisReport-Final.pdf.

York should not have to reinvent these models from scratch, and a well-constituted task force with real authority to make recommendations can move this work forward efficiently.

Perhaps the most pervasive challenge 988 faces, however, is simply that most people do not know it exists. We learn to call 911 from childhood. 988 is new, and its appropriate uses are more nuanced. Many New Yorkers experiencing a mental health crisis, or witnessing one, reach for 911 by default, not because it is the right call, but because it is the only one they know. The public education campaign required by this legislation addresses that gap directly, providing communities with clear, accessible information about when to call 988, what to expect, and what services are available. Critically, the bill requires this outreach in designated citywide languages, which is essential to reaching the communities that are most overpoliced and least connected to behavioral health services.

We want 988 to become the default response to mental health crises in New York City. Every call that goes to 988 instead of 911 is an opportunity to connect someone to care rather than to the criminal legal system. This legislation will not fix everything, but it builds the infrastructure, the accountability, and the public awareness that a functioning 988 system requires. We urge its passage.

III. State Legislation That Would Open Connections to Mental Health Services for Justice-involved New Yorkers.

New York County Defender Services supports the Treatment Court Expansion Act (S.4547/A.4869), state legislation that would establish the statutory framework necessary to meaningfully connect individuals in the criminal legal system to mental health treatment. More specifically, this bill would expand and modernize New York's network of treatment courts, reducing our reliance on prisons and jails while addressing the growing mental health crisis across New York state.

In our daily practice, we represent thousands of individuals whose criminal legal involvement is linked to untreated or poorly treated mental health conditions. However, access to treatment through the courts currently depends on a patchwork of diversion programs operating without uniform statutory authority. While every county has a "judicial drug diversion" program as mandated by statute, these programs operate under very exclusionary eligibility criteria, admissions procedures, and control.

In many jurisdictions, including Manhattan, admission to any of the various mental health diversion programs is dependent on prosecutor approval. This leads to lengthy, burdensome application requirements that exclude far too many and substantially delay entry into care. Applicants are typically required to undergo multiple sequential screenings that take months at a time, including submitting years of medical records to be reviewed by the DA's office, and

personally meet with the Manhattan DA's office for extensive interviews about their personal, healthcare, and legal histories and needs.

These barriers and delays often prolong incarceration or leave people destabilized in the community for months on end without the services they require. It's not uncommon for people to languish at Rikers for over a year during this arduous screening process without any real sense of certainty. Importantly, applicants can be rejected by the DA or the specialty court in question at any point of the lengthy screening process.

The absence of a clear, statewide legal framework is a barrier to treatment. Without statutory authority, there is no consistent, reliable pathway from the courtroom to community-based care for people with mental health challenges. TCEA addresses this structural deficiency. By amending Criminal Procedure Law Article 216 to authorize treatment opportunities for both substance use and mental health conditions statewide, and lifting the arbitrary admissions criteria that currently exclude so many deserving candidates, this bill creates a uniform legal mechanism where eligible individuals can seek diversion. It clarifies roles, streamlines the admissions process, and places judicial oversight at the center of eligibility determinations, which reduces the unnecessary delays cited above and promotes equitable access for individuals with a serious mental health diagnosis.

The significance of this reform lies not only in expanding treatment courts, but in formalizing access to care as a legally recognized pathway. A clear statutory structure will ensure that individuals whose conduct is driven by mental health conditions are connected to appropriate services, rather than continuing to cycle through the criminal justice system. For our clients, TCEA creates a clear legal pathway from destabilization and incarceration to treatment and community reintegration.

IV. Conclusion

NYCDS supports **Intro 0722-2026 and T2023-3879.** We ask that you improve SPOA by creating a secure portal where people can check where they are on the waitlist and improve accessibility to Emergency Transitional Housing by putting all applications in one centralized repository. Ultimately the City Council needs to invest in all forms of behavioral providers from FACT teams to IMT to address our mental health crisis, as well as deliver on its promise to provide 500 JISH units to support the stabilization of people cycling between Rikers, shelters, and other institutions. The City also needs to call upon the state to pass the Treatment Court Expansion Act (S4547/A4869). Our mental health system is our legal system. We are at a critical moment to change that.

If you have any questions about my testimony, please email policy@nycds.org.

TESTIMONY OF NORTHSIDE CENTER FOR CHILD DEVELOPMENT, INC.

New York City Council Committee on Mental Health and Substance Use

Submitted by Paula Magnus, President

March 4, 2026

Good morning, Chairperson and members of the Committee.

My name is Paula Magnus, President of Northside Center for Child Development. Northside has served children and families in Harlem for over 80 years. We operate our main behavioral health clinic at 1475 Park Avenue in Harlem and school-based behavioral health clinics in 23 schools across Manhattan and the South Bronx. We are also the sole designated COMHPS provider for both Manhattan and the Bronx, appointed by the New York State Office of Mental Health to deliver community mental health outreach across the two boroughs at the center of today's hearing. No other COMHPS agency in New York City serves both boroughs. That position gives us a direct and specific view of what this Committee is examining. We strongly support both bills on the agenda and offer testimony on each.

T2023-3879: 988 Task Force and Public Education Campaign

Northside strongly supports this bill. Our COMHPS Community Wellness Specialists are in Harlem and the Bronx every weekday, in community organizations, at community events, and in conversation with residents navigating stress, grief, trauma, and mental health challenges. What they encounter consistently is the gap this bill is designed to close: residents who do not know 988 exists, do not understand what it does, or do not trust it enough to call.

Our Community Wellness Specialists report that most residents they encounter have never heard of 988. Among those who have, the dominant misconception is that 988 is exclusively for suicidal crisis. Residents do not know that 988 counselors provide emotional support for anyone who simply needs someone to talk to, that 988 connects callers to referrals for mental health providers, or that it is available by call, text, or chat, free and confidential, 24 hours a day, seven days a week. This misunderstanding matters because it means residents in genuine distress are not calling, not because they do not need help, but because they do not believe 988 is for them.

The task force component addresses how 988 functions once someone calls: call-taker training, scripts, mobile crisis protocols, and outcome metrics. Those elements need independent examination. We strongly support the task force and recommend it include community-based providers and people with lived experience, not only agency administrators.

The public education campaign is where Northside's COMHPS role is most directly relevant. As the sole Manhattan and Bronx COMHPS provider, we are the designated infrastructure for exactly this kind of community outreach. A campaign that reaches the residents who most need 988 cannot be delivered through mass media alone. It requires trusted messengers already embedded in these communities, working in the languages those communities speak.

Northside's COMHPS materials are currently available in English and Spanish. Our flyers reference both the COMHPS direct line (646-329-7135, Monday through Friday, 10am to 6pm) and the 988 Lifeline as a 24/7 free and confidential option for support, available by call, text, or chat at 988LIFELINE.ORG. These materials are distributed at community events, parent workshops at Northside and partner schools and community organizations, and through partner organizations across Harlem and the Bronx. The 988 program has provided some supplemental materials including stickers, cards, and bracelets, but our team reports those items are currently on back order.

A well-resourced public education campaign needs to go beyond mass media. It should leverage trusted community messengers like COMHPS teams, specify the full range of services 988 offers beyond crisis intervention, including emotional support and referrals to providers, and explain concretely how 988 differs from calling 911, ideally through role-playing, interactive videos, and similar formats distributed through community channels and partner organizations.

Int 0722-2026: Reporting on Mental Health Emergency Response Data

Northside strongly supports this bill. Our vantage point is specific: we are the COMHPS provider for both Manhattan and the Bronx, we operate our main behavioral health clinic in Harlem, and we run school-based behavioral health clinics in Manhattan and the South Bronx, all neighborhoods where mental health emergencies occur daily. When a 911 call goes out for a mental health crisis in those neighborhoods, no data trail connects that response to us and no referral protocol exists to close that gap.

B-HEARD teams responding to mental health emergencies in those neighborhoods may be encountering children and families we serve. We would not know, because no referral protocol we are aware of connects a B-HEARD response to community-based providers like Northside.

We can confirm: Northside has never received a referral from a B-HEARD team. Our COMHPS Community Wellness Specialists, who work daily in the neighborhoods B-HEARD serves, were not familiar with B-HEARD prior to preparation of this testimony. The City's COMHPS program coordinator has provided no training or guidance on B-HEARD coordination. That gap is not a criticism of individual responders. It reflects a structural absence of any referral protocol connecting crisis response to the community-based infrastructure that already exists to provide follow-up care.

Quarterly public reporting on mental health emergency responses, including whether B-HEARD was dispatched and able to respond, is a necessary foundation for accountability.

But data transparency alone will not close the gap between crisis response and ongoing community care. We urge the Committee to pair this reporting mandate with a requirement that relevant City offices develop formal referral protocols connecting B-HEARD responses to community-based providers operating in the same neighborhoods, starting with the COMHPS network that already exists for exactly that purpose.

We appreciate the opportunity to testify and welcome any questions.

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Samaritans

Working together to prevent suicide + help save lives.

Casey Starr

ORAL TESTIMONY

Co-Executive Director, The Samaritans of New York, Inc.

From Crisis to Care: How New York City Connects New Yorkers to Mental Health Services

March 4, 2026

Chairs Caban, Lee, and Shulman — thank you for the opportunity to testify.

My name is Casey Starr, and I am the Co-Executive Director of Samaritans of New York. For more than forty years, Samaritans has provided confidential and anonymous suicide prevention support to New Yorkers, twenty-four hours a day, staffed entirely by trained volunteers.

In addition to my role at Samaritans, I serve on the National Council for Suicide Prevention and work internationally with Befrienders Worldwide, the largest global suicide prevention network. Through that work I have been involved with many different crisis response models, governance structures, and accountability frameworks.

Samaritans supports all three items before you today.

Trust is what is at stake today and **trust depends on transparency.**

At a minimum, the Council should have access to aggregate reporting on key 988 performance indicators, including:

- call, text, and chat volume
- wait times and call abandonment rates
- cross-state routing and use of national backup centers
- risk levels identified during contacts
- emergency dispatch and mobile crisis deployment
- referral patterns and the types of services callers are connected to

This information can be shared in aggregate form without compromising confidentiality, and it is already being collected.

Transparency allows policymakers to understand how the system is functioning, where people are being directed for care, and where improvements may be needed.

But transparency is only part of the larger conversation.

As New York strengthens centralized crisis systems like 988 and SPOA, it is important to remember that suicide prevention does not occur only within centralized intake systems.

It happens across the broader health and social service landscape.

Community organizations, healthcare providers, schools, and local hotlines all play important roles in helping people reach support.

When we become overly reliant on a single system — whether that is SPOA for services or 988 for crisis access — we risk weakening the very safety net we are trying to build.

Large systems are designed for capacity and scale.
Community-based services are often designed for trust and relational continuity.

Those are different strengths.

A well-functioning crisis system needs both.

988 may be the front door to crisis care, but that does not mean we should turn all the other lights off.

The same is true for SPOA.

When we focus too heavily on a single system, the goal of coordination can begin to look like consolidation. Instead of expanding access to care, we risk narrowing the ways people can reach it.

In a city as diverse as New York, people need to be able to access help in the ways that feel safest and most comfortable to them.

A strong crisis system preserves multiple pathways into support.

Thank you.

Full written testimony submitted separately.

Samaritans

Working together to prevent suicide + help save lives.

Fiodhna O'Grady

ORAL TESTIMONY

Director of Government Relations, The Samaritans of New York, Inc.

From Crisis to Care: How New York City Connects New Yorkers to Mental Health Services

March 4, 2026

Chairs Lee, Cabán, and Shulman, and members of the Committee, thank you for the opportunity to testify today.

My name is Fiodhna O'Grady, and I am the Director of Government Relations for Samaritans of New York.

I would like to focus specifically on the operational oversight of 988 and the importance of transparent reporting within complex crisis systems.

The 988 network operates as a distributed national system of crisis contact centers. This network model allows crisis services to remain rooted in communities while maintaining national coordination.

Local centers bring cultural competence, knowledge of regional resources, and relationships with community providers.

Historically, this distributed model has been one of the Lifeline's greatest strengths.

However, New York occupies a unique position within that structure.

Vibrant Emotional Health administers the national 988 network infrastructure while also operating one of the largest crisis contact centers within that same network.

This reflects significant experience and leadership in crisis services. At the same time, it makes local transparency and oversight especially important.

Large crisis centers also frequently serve as capacity stabilizers for the national network during periods of high demand. As a result, some calls answered in New York may originate outside the city or even outside the state.

Transparent reporting should therefore distinguish between:

- contacts originating from New York City residents
- contacts originating elsewhere in New York State
- contacts routed through the national backup network

Without this information, policymakers cannot accurately evaluate local demand, system capacity, or the allocation of public resources.

Oversight should also examine how the system integrates with the broader crisis continuum.

New York's crisis infrastructure now includes multiple entry points, including:

- 911 emergency response
- 988 crisis services
- B-HEARD teams
- mobile crisis teams
- community-based services and hotlines

Understanding how individuals move across these systems is essential for evaluating how the crisis continuum functions in practice.

Finally, transparency around reimbursement structures and quality assurance metrics is essential to ensure that funding models do not inadvertently create incentives that could influence clinical decision-making.

Strong oversight supports strong systems.

Thank you.

Full written testimony submitted separately.

Samaritans
SUICIDE PREVENTION CENTER

ABOUT US

Our mission is to prevent suicide + help save lives.

For over 40 years, Samaritans has been a trusted leader in suicide prevention in New York City.

As part of the world's largest suicide prevention network, spanning 48 countries, we are committed to delivering life-saving support to individuals and communities in need.

Samaritans' programs provide immediate and ongoing support to people in crisis, solace to those touched by suicide, and education for caregivers, health providers, and the public on suicide prevention and how to respond to those at risk.

CRISIS HOTLINE

*NYC's only **anonymous + completely confidential** suicide prevention and crisis hotline.*

The hotline provides free, immediately available emotional support from caring, professionally trained community volunteers.

Open 24 hrs. a day, 7 days a week.

212-673-3000

No judgment. Just support

WELLNESS SUPPORT LINE

Our free mental health wellness line offers proactive, scheduled support for people who want to check in about their mental health before reaching a point of crisis.

To learn more or to schedule a call, go to:

samaritansnyc.org/wellness-line

SUICIDE LOSS BEREAVEMENT

Samaritans' Safe Place program offers a supportive environment for those bereaved by suicide to cope with the loss of a loved one alongside others who truly understand what they are going through.

Safe Place meetings take place 4 times per month and are available in both in-person and virtual settings.

To learn more or register for a meeting, go to:

samaritansnyc.org/get-support-bereavement-services

SUICIDE PREVENTION EDUCATION

From webinars to comprehensive, in-person trainings, our programs Samaritans' education programs equip individuals with the knowledge and skills they need to confidently identify and respond to those at risk. Offerings are tailored for both community members and professionals.

Samaritans is the only organization offering suicide prevention training alongside 24-hour hotline support.

To learn more, go to:

samaritansnyc.org/education-services

Samaritans

Working together to prevent suicide + help save lives.

Kumarie Cruz

ORAL TESTIMONY

Director of Bereavement and Education Services, The Samaritans of New York, Inc.

From Crisis to Care: How New York City Connects New Yorkers to Mental Health Services

March 4, 2026

Chairs Lee, Cabán, and Shulman, and members of the Committee, thank you for the opportunity to testify.

My name is Kumarie Cruz, and I am the Director of Bereavement and Education Services at Samaritans of New York.

In my work, I support individuals and families who have been touched by suicide, and I work closely with communities across New York City to strengthen suicide prevention education.

From that perspective, I want to focus on something that determines whether crisis systems actually work: trust.

A crisis system only works if people trust it enough to reach out.

For many people, that decision depends on whether they believe they will maintain autonomy, whether their conversations will remain confidential, and whether seeking help could lead to consequences they did not intend.

New York City has made important commitments to least-restrictive crisis response and to minimizing unnecessary police involvement in behavioral health emergencies.

From a suicide prevention perspective, crisis intervention should prioritize:

- Autonomy
- voluntary engagement
- Confidentiality
- harm reduction and least-restrictive care

These principles matter because they directly influence whether people feel safe asking for help.

If people fear losing control when they reach out, they may not reach out at all.

This concern is particularly important for communities that have historically experienced harm within formal systems, including undocumented residents, LGBTQ+ youth, and communities of color.

Another important reality is that many people never enter crisis systems through formal entry points.

They may reach out first to a trusted community organization, a healthcare provider, a school counselor, or a local hotline.

These trusted relationships often represent the moment when someone first feels safe enough to talk about what they are experiencing.

For many individuals, the difference between reaching out and remaining silent is whether they can do so in a way that feels safe and familiar.

A well-functioning crisis system therefore needs both scale and trust.

Large systems provide capacity.

Community-rooted services provide connection.

When those two strengths work together, people are more likely to reach the support they need.

Thank you.

Full written testimony submitted separately.

Vera INSTITUTE OF JUSTICE

New York City Council Committee on Mental Health & Substance Use
Oversight Hearing: From Crisis to Care

Written Testimony of Benjamin Heller
Program Manager, Greater Justice New York
Vera Institute of Justice

March 4, 2026

My name is Benjamin Heller, and I am the program manager of the Greater Justice New York initiative at the Vera Institute of Justice, which works to end mass incarceration, protect immigrants' rights, ensure dignity for people behind bars, and build safe, thriving communities. Thank you for the opportunity to provide testimony.

Over the last decade, the number of people in our city's jails experiencing mental illness has skyrocketed. In fiscal year (FY) 2015, 11.1 percent of people in Department of Correction (DOC) custody had a serious mental health diagnosis.[1] By FY2025, that share had nearly doubled to 20.7 percent—and more than half of those in custody were eligible for mental health discharge planning upon release.[2]

Instead of ensuring access to robust, community-based mental health care, our city increasingly relies on the criminal legal system to respond to behavioral health needs—and this has contributed significantly to the ballooning jail population, hindering New York City's commitment to close Rikers Island by 2027.[3] Police, courts, and jails, however, do not provide effective treatment, and incarceration often worsens mental health outcomes.[4] Removing people from their communities when they need care, not punishment, inflicts harm on them and the people around them.

To improve community-based mental health treatment, the city must start by focusing on three main priorities:

1. Assessing and scaling existing services;
2. Improving mental health emergency response; and
3. Creating a strategy to train, hire, and retain behavioral health workers to expand access to care and services.

Managing at least some of these efforts should be within the scope of an eventual Department of Community Safety. Even absent such a dedicated agency, advancing these focus areas will help connect New Yorkers with mental illness to treatment and care—instead of arrest and incarceration.[5]

The city must ensure that existing community-based mental health treatment options can meet demand. As of March 2025, Intensive Mobile Treatment (IMT) and Assertive Community Treatment (ACT) teams had waitlists of 672 and 682 people, respectively.[6] The city council must pass legislation requiring the Department of Health and Mental Hygiene to regularly report on waitlists for IMT, ACT, and related services, which will enable city government to make data-driven funding decisions. Expanding capacity will allow more people to access voluntary care—improving stability without resorting to involuntary hospitalization, arrest, or incarceration.

Even with well-resourced, community-based care, mental health crises will still happen. When they do occur, the city must send trained peer specialists and clinicians, not police. Recent tragedies, like the shooting of Jabez Chakraborty, underscore the consequences of an inadequate mental health crisis response.[7] The Substance Abuse and Mental Health Services Administration's national guidelines emphasize that it is "unsafe and unacceptable" to rely on police as the primary responders to mental health crises.[8] Beyond successfully connecting people to care, civilian crisis response can free up police resources to focus on violent crime, further strengthening community safety.[9]

The city's current mental health crisis response, B-HEARD, only operates from 9:00 a.m. to 1:00 a.m. in just 31 out of 78 city precincts. Call triage limitations and narrow eligibility criteria have meant that, from January 2022 through September 2024, 60 percent of mental health calls resulted in a police-first response.[10] Similarly, in the third quarter of 2025, only 41 percent of "emotionally disturbed person" (EDP) calls were deemed eligible for a B-HEARD response.[11] Even when calls qualify, limited operating hours can hinder response: between January and September 2024, 3,652 eligible calls did not receive a B-HEARD response because the program was offline.[12]

To close this gap, the city should update 911 triage and dispatch to make more EDP calls—including instances of self-harm—eligible for B-HEARD. Police should not be dispatched before EMS has a chance to triage a call. Strengthening training and support for call takers will help them better determine safety risk, and embedding behavioral health professionals in dispatch centers will further improve decision-making. In addition, the city should add peer specialists to teams where appropriate, consistent with research demonstrating their effectiveness both in New York and across the country.[13]

As these services expand, adequate funding will be essential. B-HEARD's $35 million budget for FY2026 is a mere 35 percent increase from its FY2022 budget—despite a nine-fold increase in the number of precincts serviced by B-HEARD over that same timeframe.[14]

Increasing the availability of community-based mental health services will also require a larger behavioral health workforce. To accomplish this, the city should mobilize a comprehensive behavioral workforce development strategy, leveraging existing assets like NYC Health + Hospitals' Peer Academy, Community Access's Howie the Harp, and other initiatives run by the Mayor's Office of Community Mental Health. This will enable the city to grow mental health services at the scale required to meet increasing need.[15]

Voluntary, community-based mental health services make our communities safer. By expanding and strengthening them, the city can support people before a crisis pushes them into the criminal legal system, improving community well-being and safety for everyone. Incarceration cannot meet people's mental health needs, let alone do so with dignity or compassion.[16]

Thank you for focusing this oversight hearing on such an important issue and thank you for the opportunity to provide testimony. Please contact me at bheller@vera.org if the Vera Institute of Justice may provide further support.

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Testimony of

Charles Corbin

Peer Advocate

Before the

Committee on Mental Health

From Crisis to Care: How New York City Connects New Yorkers to Mental Health Services.

March 4, 2026

My name is Charles Corbin, and I stand before you not just as a professional in the human services field, but also as someone who has lived through the justice system and understands the struggles that bring people into these courtrooms. My story is a testimony that transformation is possible when opportunity, accountability, and support come together.

Testimony in Support of the Treatment Court Expansion Act (S.4547/A.4869)

We have criminalized mental health challenges. So many people in desperate need of care will become entangled in the criminal legal system. We cannot punish ourselves out of a mental health crisis. We need the state to enact the Treatment Court Expansion Act and we need the City and State to invest in the treatment providers who make diversion meaningful.

Mental Health on Rikers Island Is at a Breaking Point

Sixty percent of people in custody at Rikers Island now require mental health services, up from 42% in 2016.[1] The rate of serious mental illness has climbed to 22%.[2] These are extraordinary figures for a setting that is fundamentally incompatible with therapeutic care.

Jail environments do not heal people. They exacerbate psychiatric symptoms, destabilize individuals, and increase the likelihood of rearrest. Nearly half, 47%, of people with serious mental illness return to Rikers within a year,[3] underscoring a devastating cycle of institutionalization that serves no one.

As the number of detained individuals with mental health needs continues to rise, the system is straining beyond capacity. The most recent Deaths in Custody report from the New York City Board of Correction found that five of seven fatalities involved people with serious mental health conditions.[4] Correctional Health Services lacks the staffing and resources necessary to provide timely evaluations, adequate treatment, or consistent clinical rounding. Even basic standards of medical care are not reliably met.

In 2024, a whistleblower revealed the widespread use of "deadlocking," a practice in which individuals in acute psychiatric distress were denied showers, out-of-cell time, and access to prescribed medications for days, weeks, or months at a time.[5] This is not treatment. It is destabilizing, deeply traumatizing, and it compounds the very suffering that brought these individuals into the system in the first place.

What happens at Rikers is not care. It is a costly and inhumane cycle, and we have the tools to interrupt it.

The Treatment Court Expansion Act Is the Right Solution

Judicial diversion provides the necessary opportunity to treat the root causes of criminal legal involvement rather than simply cycling people through incarceration. The Treatment Court Expansion Act would amend Criminal Procedure Law 216, the statute that established drug courts in every county, to add mental health courts statewide. It would also modernize and expand accessibility by strengthening due process protections, aligning with clinical best practices, and removing charge-based exclusions that have arbitrarily denied participation to people who would meaningfully benefit.

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[1] https://datacollaborativeforjustice.org/wp-content/uploads/2025/11/Katal_DCJ_Report_.pdf
[2] Id.
[3] https://www.thecity.nyc/2026/02/18/rikers-doc-deml-richards-problems-solutions/
[4] https://www.nyc.gov/assets/boc/downloads/pdf/second-report-and-recommendations-on-2025-deaths-in-doc-custody.pdf
[5] https://ny1.com/nyc/all-boroughs/politics/2024/10/11/rikers-detainees-whistelblower-mental-health-care-

The county where someone lives should not determine whether a mental health challenge means they go to jail.

After the point of arrest, we need sufficient off-ramps to ACT teams, FACT teams, and supportive housing, and those programs must be fully funded and functional. The Treatment Court Expansion Act creates the judicial architecture for those off-ramps to work. For many individuals, mental health court will represent their first connection to critical health services. For others who have cycled through the system multiple times, the court functions as an essential case manager, ensuring continuity of care in a city with deeply siloed resources that would otherwise require nearly a full-time job to navigate.

We Need Investment in Treatment Providers

We cannot discuss treatment court expansion without confronting the treatment infrastructure it depends on. Diversion only works when there is a soft place to land.

Waitlists for supportive housing can run from one month to a year.[6] A city of 8.5 million people has just 100 beds in Mobile Health Respite Teams.[7] That is not a system; it is a gap.

We urge the City Council to invest in our public health infrastructure with the same urgency we bring to public safety, because they are the same thing. Enacting the Treatment Court Expansion Act while failing to fund the treatment ecosystem it requires would be an incomplete solution. People leaving court-mandated diversion need stable housing, clinical support, and community-based care. Without those investments, we are building a door with nowhere to walk through.

We have criminalized mental health challenges long enough. It is time to treat them.

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[6] https://www.thecity.nyc/2025/01/06/homeless-supportive-housing-eric-adams-statistics/

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: 3/4/26

(PLEASE PRINT)

Name: Laura Savino

Address: [redacted], Maplewood, NJ

I represent: FdL

Address: 125 Broad Street, NYC

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☑ in favor ☐ in opposition

Date: 3/4/2026

(PLEASE PRINT)

Name: Razia Begum

Address: Arab American Family Support Center

I represent: ________

Address: ________

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Frances Geteles

Address: [redacted] [illegible]

I represent: HALT Solitary, Jail Action

Address: [illegible] Solitary Confinement

Please complete this card and return to the Sergeant-at-Arms

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 722-2026

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Christina Sparrock, NYLPI

Address: New York Lawyers for the Public Interest

I represent: _____

Address: _____

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THE CITY OF NEW YORK

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Tom Harris

Address: [redacted] 1560 Broadway

I represent: Times Square Alliance

Address: 1560 Broadway

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3.4.26

(PLEASE PRINT)

Name: RUTH O'SULLIVAN

Address: [redacted]

I represent: CENTER FOR JUSTICE INNOVATION

Address: 520 8th avenue

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Danielle Regis

Address: 177 Livingston St, Brooklyn, NY 11201

I represent: Brooklyn Defender Services

Address: 177 Livingston St, Brooklyn, NY 11201

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Carly Shapiro

Address: 100 William St 120 NY, NY 10038

I represent: New York County Defender Services

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Paula Magnus

Address: _____

I represent: Northside

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Jordyn Rosenthal

Address: 1 State Street

I represent: Community Access

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Van Yu

Address: _____

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

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Hector Garcia

Address: _____

I represent: Goodwill, Lantern House Clubhouse

Address: _____

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/4

(PLEASE PRINT)

Name: Laura Savino

Address: _____

I represent: Institute for Community Living

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/4/26

(PLEASE PRINT)

Name: Dr. Jean Wright

Address: _____

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

MH

Date: _____

(PLEASE PRINT)

Name: KUMARIE CRUZ

Address: _____

I represent: The Samaritans Suicide prevention center

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

MH

Date: _____

(PLEASE PRINT)

Name: Fiodhna O'Grady

Address: _____

I represent: THE SAMARITANS of NEW YORK SUICIDE PREVENTION CENTER

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Charles Corbin The Proper Perspective inc

Address: 16 Lake Kitchawan Drive

I represent: Treatment Court Expansion Act

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 722 Res. No. _____

☑ in favor ☐ in opposition

Date: 3/4/26

(PLEASE PRINT)

Name: Jonathan Chung

Address: _____

I represent: NAMI-NYC

Address: 307 W. 38th St.

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: March 4, 2026

(PLEASE PRINT)

Name: Benjamin Heller

Address: _____

I represent: Vera Institute of Justice

Address: 34 35th St Suite 4-2A Brooklyn NY 11232

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Nadia Chait

Address: 4 West 125th

I represent: CASES

Address: 4 West 125th

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Ronald Jones

Address: [redacted]

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/04/26

(PLEASE PRINT)

Name: CASSANDRA STUART

Address: 110 WILLIAM ST, NY, NY 10038

I represent: NYC INDEPENDENT BUDGET OFFICE

Address: 110 WILLIAM ST, NY, NY 10038

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/4/2026

(PLEASE PRINT)

Name: ED DOLAN

Address: 110 WILLIAM ST 14TH FLOOR

I represent: NYC INDEPENDENT BUDGET OFFICE

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: Jamie Weckles

Address:

I represent: Administration

Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Rebecca Lin-Walton

Address: _____

I represent: Admin

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: [redacted] Dr. Jean Wright

Address: _____

I represent: Administration

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 722 Res. No. _____

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: Laqusha Grant

Address: 253 Broadway, New York, NY 10007

I represent: Mayor's Office of Community Mental Health

Address: 253 Broadway

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/4/2026

(PLEASE PRINT)

Name: Safina Tanni

Address: _____

I represent: Asian American Federation (Panel with Razia Begum)

Address: _____

Please complete this card and return to the Sergeant-at-Arms