CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON MENTAL HEALTH AND SUBSTANCE USE

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March 4, 2026
Start: 10:13 a.m.
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HELD AT: 250 BROADWAY - 8TH FLOOR - HEARING ROOM 2

B E F O R E: Tiffany Cabán, Chairperson

COUNCIL MEMBERS:
Shirley Aldebol
Joann Ariola
Simcha Felder
Linda Lee

OTHER COUNCIL MEMBERS ATTENDING:
Lynn C. Schulman
Jumaane Williams, Public Advocate

A P P E A R A N C E S

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

Jamie Neckles, Assistant Commissioner for the Bureau of Mental Health at the New York City Department of Health and Mental Hygiene

Dr. Rebecca Linn-Walton, Assistant Commissioner for the Bureau of Alcohol and Drug Use at the New York Department of Health and Mental Hygiene

Laquisha Grant, Mayor's Office of Community Mental Health

Cassandra Stuart, Lead Budget and Policy Analyst on Health at the New York City Independent Budget Office

Ed Dolan, Senior Policy Advisor at the New York City Independent Budget Office

Jordyn Rosenthal, Director of Advocacy at Community Access

Nadia Chait, Senior Director of Policy and Advocacy at CASES

Benjamin Heller, Program Manager at the Vera Institute of Justice

Danielle Regis, Senior Supervising Attorney in the Mental Health Representation Team of the Criminal Defense Practice at Brooklyn Defender Services

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

Van Yu, Chief Medical Officer of the Center for Urban Community Services

Fiodhna O'Grady, Government Relations Director for the Samaritans of New York

Kumari Cruz, Director of Bereavement and Public Education Services at Samaritans of New York

Razia Begum, Mental Health Clinician Supervisor at the Arab American Family Support Center

Sofina Tani, Senior Program Coordinator at the Asian American Federation

Jonathan Chung, National Alliance on Mental Illness of New York City

Ryan Smith, Director of the City of Durham's Community Safety Department in Durham, North Carolina

Ruth O'Sullivan, Senior Director of Clinical Practice for the Center for Justice Innovation

Paula Magnes, President of Northside Center for Child Development

Carly Shapiro, Forensic Social Worker at New York County Defender Services

Laura Savino, Senior Vice President for Care Management at Institute for Community Living

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

Christina Sparrock, Alternative Crisis Response Researcher at the Disability Justice Program at New York Lawyers of the Public Interest

Frances Geteles, clinical psychologist and advocate

Hector Garcia, Director of Lantern House Clubhouse

Tom Harris, President of the Times Square Alliance

Zev Vel, Program Director of Goddard Riverside's Intensive Mobile Treatment Program

Sakeena Trice, Staff Attorney with the Disability Justice Program at the New York Lawyers for the Public Interest

Jihoon Kim, President and Chief Executive Officer of InUnity Alliance

Nicole Robinson-Etienne, Senior Director of External Affairs at LinkNYC

Christopher Leon Johnson, self

SERGEANT-AT-ARMS: Check. Sound check. This is a microphone check on the Committee on Mental Health and Substance Use, recorded by Simone Eno (phonetic) in Hearing Room 2 on March 4, 2026.

SERGEANT-AT-ARMS: Quiet, please.

Good morning, and welcome to the New York City Council hybrid hearing of the Committee on Mental Health and Substance Use.

Please silence all electronic devices at this time.

If you have any questions, please raise your hand, and one of us, the Sergeants-at-Arms, will kindly assist you.

Chair, we are ready to begin.

CHAIRPERSON CABÁN: Good morning, everyone. My name is Council Member Tiffany Cabán, Chair of the New York City Council's Committee on Mental Health and Substance Use. Before we begin, I'd like to recognize that we are joined by the following Council Members, Council Member Schulman, Lee, Aldebol, Ariola on Zoom, Felder, and we are also joined by the Public Advocate.

Today's oversight topic is From Crisis to Care: How New York City Connects New Yorkers to

Mental Health Services, and we will also be hearing two bills, Introduction 722, sponsored by Council Member Schulman, which would require the quarterly reporting and publication of mental health emergency response data relating to B-HEARD, and Pre-Considered Introduction sponsored by Council Member Lee and myself, which would establish a task force to study the current 9-8-8 system and create a public education campaign on mental health awareness.

I want to begin today's hearing by speaking briefly about the case of Jabez Chakraborty, New Yorker from Jamaica, Queens. His story reflects the broader systemic challenges in how we respond to and support individuals living with a serious mental illness. Jabez is 23 years old and lives with schizophrenia and receives treatment and medication. After a mental health crisis in December, his family called 9-8-8 and requested a mobile crisis team, and the team didn't arrive at his home until two days later. He wasn't taken to the hospital, and his family was then advised to request involuntary transport, after which Jabez was discharged after just three days. His family attempted to enroll him in an intensive daily treatment program, but he was

placed on a waitlist. And I just want to point out that a lot of what we end up seeing and talking about in a person's life like this, that culminated in a police officer shooting him while he was in a mental health crisis, people will watch the video and say, well, I don't know, this is complicated, it's justified because this young man was holding a knife. But it does not take into context every single moment that him and his family was failed, that he could have had access to a sustained continuum of care that could have prevented the crisis, and it does not change the fact that these officers were fundamentally the wrong responder, period. And it could have had a fatal outcome, and I mean, we're lucky that he is still alive today, but also that trauma is one that's going to last a lifetime for him and his family, and it is an utter failure by our City that that is how this culminated. I think this moment points to one of the most persistent gaps in our mental health system, and it's the space between stabilization and sustained care. A hospital stay or crisis intervention, however necessary, is not a destination. It's a bridge. And without timely connection to programs like intensive mobile

treatment, assertive community treatment, long-term community-based supports, individuals like Jabez are left to navigate an often-fragmented system on their own, and families are left holding the weight of that failure. And on the morning of January 26, Jabez experienced another crisis. His family once again sought emergency assistance, and what followed was a tragic encounter with law enforcement, and it could have been prevented.

And so, this case illustrates the profound consequences of gaps in coordination and of a system that too often treats crisis response as the end of care rather than the beginning of it. And when institutions are under-resourced, when families cannot access timely support, and when waitlists and red tape block access to ongoing treatment, the burden falls hardest on those who are the most vulnerable. And at its core, connecting New Yorkers to mental health care is not just a public safety issue. It's a matter of dignity. People living with mental illness are not problems to be managed or crises to be contained. They are our neighbors, our family members, our colleagues. They deserve the same opportunity as anyone else to live full, meaningful

lives and to be active, valued members of their communities. And when we fail to provide timely, sustained, and compassionate care, we are not just failing a system metric. We are telling a person that they do not belong, that their struggles make them other, and that is a message that no New Yorker should ever receive. And we owe it to Jabez and to every New Yorker like him to do better, not only in how we respond to crises, but in how we ensure that every person who needs sustained mental health support can actually access it. Effective care means more than stabilization. It means supporting people and building lives that they find meaningful, maintaining housing, reconnecting with family, and participating fully in their communities, and programs like intensive mobile treatment and assertive community treatment exist precisely to provide that kind of holistic, person-centered support, and we must ensure that they are funded, that they're staffed, and accessible to all who need them. And I share this story to center the voices and experiences of the New Yorkers we serve.

Through this oversight hearing, we aim to strengthen the various systems that connect people to

care, from the first call to 9-8-8 to the long-term treatment and community connection that make a full life possible. That's what this hearing is about.

So, in closing, I would like to thank the Administration for being here, as well as the Committee Staff who worked to prepare for this hearing, and my own Staff.

And I'm going to now pass the microphone to Council Member Schulman for a brief statement.

COUNCIL MEMBER SCHULMAN: Thank you very much, Chair. And I just, before I get into my statement, I want to echo what the Council Member said. And also, you know, the bridge we talk about. I used to work in the Health and Hospitals system some years back, and even that bridge doesn't work because folks come in, and then because there's no money to keep them, they don't keep them, and then they put them out on the street. So that's not a response, that's not an answer. And the case she's talking about, there's thousands of them like that.

So, I want to talk about, good morning, everyone. To Chair Cabán, thank you for having me here today, and Members of the Committee on Mental Health and Substance Use. I'm Council Member

Schulman, Chair of the Committee on Health. I appreciate the opportunity to speak today about this important legislation that I have.

As many of you know, we are in the midst of a mental health crisis, both locally and nationally. It's estimated that about 23 percent of all U.S. adults live with a mental illness. This is in line with the 25 percent of adult New Yorkers experiencing a mental health disorder in a given year. Intro. 722 is about transparency and data, which we don't have, interestingly enough. It would require the Office of Community Mental Health to report quarterly on every 9-1-1 call identified as involving a mental health emergency, including how those calls were heard and whether a Behavioral Health Emergency Assistance Response Division, B-HEARD team, responded, and submit that report to the Mayor and City Council Speaker. Additionally, this legislation would require the NYPD and FDNY to include the unique identifiers generated by their respective computer-aided dispatch systems and to indicate whether B-HEARD was dispatched and able to respond. Why does this matter? Because we cannot improve what we do not measure. If we are serious

about building a public health-centered crisis response system, we need clear, accessible information about where B-HEARD is working, where it is not, and why. This data will also help emergency responders better prepare for emergency calls.

I want to thank the Committee on Mental Health and Substance Abuse Staff for their work on this legislation, and I urge my Colleagues to support Intro. 722. Thank you, Chair.

CHAIRPERSON CABÁN: Thank you.

And now we hear from Public Advocate Jumaane Williams.

PUBLIC ADVOCATE JUMAANE WILLIAMS: Thank you. As mentioned, my name is Jumaane Williams, Public Advocate for the City of New York. I would like to thank Chair Cabán and the Members of the Committee on Mental Health and Substance Abuse for holding this very important hearing.

Almost one in four adult New Yorkers experience a mental health disorder in a given year. Mental illness affects people across all communities and demographics, wealthy and poor, young and old, Black and White. But not everyone is able to access treatment, and not everyone who accesses treatment

gets the kind of care they need. There are many reasons why New Yorkers who need mental health care either do not or are unable to access it, including cost, stigma, language barriers, and logistics. A report published last year by DOHMH found that in 2023, about 14 percent of New Yorkers, almost a million people, reported that there was a time in the past where they did not get the mental health treatment they needed. As is the case across health care more broadly, Black, Brown, Indigenous people fare worse when it comes to receiving effective mental health treatment. There are a few instances when the police should respond to a person in a mental health crisis. More often, the presence of officers, particularly in uniform, only escalate an already tense and precarious situation. Most recently, we have seen this play out in the shooting of Jabez Chakraborty, a young man diagnosed with schizophrenia experiencing a mental health crisis. According to his family, who called emergency services, they requested EMS, not police. Mr. Chakraborty was not a threat until police arrived and the presence escalated the situation. I am thankful that Mr. Chakraborty is alive and recovering from

being shot four times, and I'm still questioning the decision to criminally charge him. The best I've heard is to help him get care, but I'm not sure if that was the best way. I want to associate myself with the words of the Chair about very often we see the last second that gets played out without everything that happened before it. What is especially tragic about the case of Mr. Chakraborty is the fact that his family repeatedly tried to connect him to crisis care in the month leading up to the shooting. In December of last year, a mobile crisis team visited him and left without transporting him to hospital. Later that month, police transported Mr. Chakraborty to a hospital, but he was discharged after three days due to understaffing. Cycling through hospitals without effective connection to care is unfortunately common. Martial Simon, the man who pushed Melissa Go in front of a train in 2022, had been hospitalized at least 20 times, according to his lawyer, either cycling in and out of the hospital or in and out of Rikers Island. Mental health care must go hand in hand with housing. A stable connection to care is nearly impossible when a person does not have a place to live, and the stress of

homelessness impedes effective treatment. As a part of the FY 2026 New York State budget, Governor Kathy Hochul insisted on expanding the criteria to involuntarily commit someone for psychiatric treatment. Now the interpretation that a person is unable to care for their basic needs, not just that they present a danger to themselves or others, is enough to involuntarily take a person for mental health evaluation, a tool which, while it's important, should be a last resort. With this law now in place, we need forceful oversight to prevent abuses, to determine whether people in the field can accurately, fairly, equitably assess individuals under the new criteria and provide help rather than perpetuate harm. It is also critical to ensure that when someone is hospitalized, they are placed on a continuum of care to ensure that people are not cycling through hospitals, jails, or homelessness. Though it can be a lifesaving tool, it is important to also name the limitations and potential harms effective of immediate insistence on involuntary treatment. Hospitalization is destabilizing and can cause a person to lose their job or housing. The goal of hospitalization is not long-term care, but

short-term stabilization, and a person who is struggling with homelessness or serious mental illness prior to hospitalization is less equipped to comply with a longer-term treatment plan, especially without additional community-based support. Research shows that involuntary commitment can negatively affect a person's earnings, which leads to poor outcomes. It can also show distrust with healthcare, which is problematic when a person needs voluntary continual care outside of the hospital. Every person with a mental health condition is different. There are no perfect solutions. It is clear, however, that the City has not yet met its mandate to properly care for some of the most vulnerable communities. I look forward to working with this Administration to ensure that those in need of care are met with compassion and dignity. I expect they have the same kind of expectations I did, unlike the last Administration where we struggled. Thank you very much.

CHAIRPERSON CABÁN: Thank you.

And now we hear from Council Member Lee to give some remarks.

COUNCIL MEMBER LEE: Thank you, Chair Cabán, and it's very exciting to see you in this new

role and very excited for your heart, passion, and dedication to continual care and crisis management work so very excited to see what you do with this Committee. And it's great --

CHAIRPERSON CABÁN: We're each other's biggest cheerleaders --

COUNCIL MEMBER LEE: Yeah.

CHAIRPERSON CABÁN: -- if you hadn't noticed.

COUNCIL MEMBER LEE: Yeah.

CHAIRPERSON CABÁN: I'm a fan.

COUNCIL MEMBER LEE: Yeah. And it's great to see a lot of the advocates here.

Good morning, everyone. And of course, Dr. Ryan, the Administration, Laquisha, nice to see all of you here. And thank you for the opportunity to speak on this legislation that I'm proud to co-sponsor with Chair Cabán.

A mental health crisis is frightening. And in that moment, people need a human voice, clear guidance, and real help. 9-8-8 is meant to be that lifeline, but New York City must ensure it consistently delivers a calm, informed, and connected response. The bill focuses on two key improvements.

Number one, a 9-8-8 Improvement Task Force. This task force will review call handling and recommend concrete improvements, including better training, de-escalation scripts, and timely dispatch of mental health professionals. The goal is to ensure people are connected to quality support after the call. And importantly, the task force will include people with lived experience. And secondly, a public education campaign. Right now, too many New Yorkers don't know what 9-8-8 is. This campaign will provide practical, everyday information on recognizing warning signs, assessing risk, when to call 9-8-8, and how to describe the situation. It will also clearly explain available services, like mobile crisis teams, and provide printed materials in community locations. People should be able to reach out and know that someone will pick up, someone will understand, and someone will help connect them to care.

And just to add, this is, I think, just a piece of the puzzle that we're trying to fix. And I think with Council Member Schulman's bill, and a lot of the other bills that we've tried passing in the Council, it really is trying to emphasize how not to let people fall through the cracks.

And I have to say, just as an anecdotal narrative perspective, whenever I go to forums or, you know, any sort of group or community meetings, I kind of do a poll test of, you know, raise your hands if you guys know what 9-8-8 is, and a lot of folks still don't know what 9-8-8 is. And I remember speaking to the folks at the State about a year and a half ago, two years ago, and there was supposed to be a lot of funding that was put into this, but, you know, hopefully those resources, I don't know if they've funneled down to the City, but hopefully that's something we can do more of around the 9-8-8 campaign to prevent deaths like Win Rozario, as well as, you know, folks like Jabez that have been shot at, and these are situations that should not happen, and so we want to make sure that our mental health system, we know it's broken. It's been deinstitutionalized. It's been underfunded for decades, and so we want to make sure we do everything possible to help the awareness side. So, thank you.

CHAIRPERSON CABÁN: Thank you very much.

Just quickly before I pass it over to the Committee Counsel, just a heads up for you all. You're going to see I have to take breaks. I've got

to stand up sometimes. I have a chronic pain issue. So, if I'm standing up, I'm not trying to lord over you, but it might be possible that I might need a bio break or something like that so, thank you.

I am going to turn the mic to the Committee Counsel to administer the oath.

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

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

ADMINISTRATION: (INAUDIBLE)

COMMITTEE COUNSEL: Thank you.

Prior to delivering your testimony, please state your name and title for the record and you may begin when ready.

EXECUTIVE DEPUTY COMMISSIONER DR. WRIGHT: Good morning, everyone. Before I read my testimony into the record, I just want to say I appreciate your sentiments and the comments you made, Chair, about the concern with the shooting and certainly much

concern as well. And although I cannot speak to individual cases specifically, I can let you know and be assured that we are looking into it internally and that we will look for all possibilities to improve and to do better, and so I appreciate the sentiments and I appreciate the sentiments of the Chairs that are here and the different Committee Members that have spoken. It's always good to see you, Chair Lee, and congratulations on being the Chair of the finance Committee, and congratulations, Chair Cabán, and it's always good to see you, Chair Schulman. It's always a pleasure. And so now I will begin my testimony.

My name is Dr. Jean Wright, and I am the 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 this 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.

First, crisis services. What constitutes a mental health crisis can look very different from person to person. You do not need to have a diagnosable mental illness or serious mental illness. A crisis may be triggered by a myriad of different internal, emotional, or cognitive experiences.

Internal or interpersonal conflicts, including abuse or violence, or environmental stressors, such as 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 colleagues from the Mayor's Office of Community Mental Health are here today to answer questions regarding the B-HEARD program, which is an important part of the mental healthcare 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 9-8-8 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, a family member, a religious advisor, a peer, a mental health professional, or a healthcare provider. Anyone can reach out to NYC 9-8-8 at any time of the day, any time of the year, and any time of the night. Anyone can also speak to a trained crisis counselor

or peer support specialist. New Yorkers can reach out via call, text, or chat. NYC 9-8-8 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 9-8-8 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 do not 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 NYC 9-8-8's 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 9-8-8 will dispatch a mobile crisis team to visit the person wherever they live within a few hours, 8 a.m. to 8 p.m., seven 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 Fiscal Year '25, 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 outpatient or inpatient care, if appropriate. We consider mobile crisis teams a short-term intervention, typically ranging from one to three contacts in a two-week period.

Some people need more support than they can access in their homes. 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 crisis. 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, and while getting additional supports through a crisis, people may be referred to a crisis residence by New York City 9-8-8, a mobile crisis team, their mental health provider, or through a self-referral. For continued support and treatment, all 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 New Yorkers is what I'll cover next. Mobile treatment programs are specialty cared

designed for individuals who have the most complex behavioral health needs. We use the term serious mental illness to refer to this combination of behavioral health and emotional needs 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, or SPOA, and contracts with community-based organizations and hospitals to administer services, namely Assertive Community Treatment Team, or ACT, the Intensive Mobile Treatment Teams, or IMT. Providers make referrals to SPOA through our website. Referral sources include crisis service providers I just described, as well as community-based mental health shelters and housing providers who recognize that their client could benefit from a high 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, assign people to the appropriate level of care and location of care. The SPOA system received 4,952 referrals in

Fiscal Year '25. 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 evidence-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, 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, or OMH, and contracted by both OMH and the Health Department. In New York City, 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, 10 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 are just some examples. 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 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 healthcare.

I will now turn to the legislation before answering any questions. Pre-introduction T-2023-3879 refers to the establishment of a task force on 9-8-8, 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 9-8-8 and mental health awareness campaigns this year. Additionally, there are mechanisms in place to improve the NYC 9-8-8 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.

EXECUTIVE DIRECTOR GRANT: Good morning. My name is Laquisha Grant, Deputy Executive Director for Mental Health Access at the Mayor's Office of Community Mental Health. And before I begin my formal

testimony, I too want to echo Dr. Wright's congratulations to Council Member Lee and to you, Chair Cabán. I know how passionate you are and how well-versed you are in nonpolice response and alternative response, and we truly look forward to working with you. So, I'll begin my testimony.

Good morning, Chair Cabán and Members of the Committee on Mental Health and Substance Use and Public Advocate Williams. 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 Intro. 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 healthcare 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 Intro. 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 the Fire Department for the City of New York in their position as a healthcare provider for the Behavioral Health Emergency Assistance and Response Division, 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, or 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 data set 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, New York City Health and Hospitals, and private hospitals that provide voluntary ambulances in the 9-1-1 system. Compliance with Intro. 722 would necessitate the hiring of data staff to design and maintain interagency data pipelines, conduct cross-system reconciliation, validation and 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 a data reporting and dashboarding tool.

Finally, there is no single 9-1-1 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 committing to advancing health-centered approaches 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.

CHAIRPERSON CABÁN: Thank you. Thank you very much. I am going to start with some brief questioning because I want to be able to hand it over to my Colleagues sooner rather than later and make sure you sign up for questions at the Committee Counsel.

I'm going to start with 9-8-8. I'm going to resist the urge to immediately go to B-HEARD, but, yeah, I'll start here. And thank you, everybody, for your testimony and for your participation. But when someone calls, texts, or chats with NYC 9-8-8, can you just talk about who answers, what are they

trained to do, and walk us through what happens in the first few minutes of contact? It was touched on a little bit in the testimony, but hoping that you can get a bit more granular there.

ASSISTANT COMMISSIONER NECKLES: Good morning. I'm Jamie Neckles, Assistant Commissioner for Mental Health at the Health Department. I can handle that question regarding 9-8-8, which is operated as a part of the National 9-8-8 Network. So, SAMHSA establishes the standards for 9-8-8 and works with local providers across the country to answer calls from their jurisdiction. Just last month, SAMHSA re-procured the national administrator contract for 9-8-8. That's routine re-procurement. So, that period closed on February 27th. In that sort of national procurement process, there's all the standards in great detail about what 9-8-8 is expected to do, and then our local expectations complement those sort of national standards. And so we have a contract for Vibrant to operate 9-8-8 locally, and they're handling about 400,000 contacts a year. Every call is answered by a trained crisis counselor. So, those are folks who go through about a month-long training to provide, there's a sort of

didactic piece and a practical piece where they're trained to answer calls with supervision and gradually independently. So --

CHAIRPERSON CABÁN: Before you go on (INAUDIBLE) can you go into that, like that month-long training, what does that entail?

ASSISTANT COMMISSIONER NECKLES: Sure. So, I'll do my best. It's a long training, so I don't know that I'll get all of the content. But basically it's learning, there's technology piece, right, for managing the call answering system and text and chats. And then there's the stages of a call, where a person comes in, you're learning how to build in a limited amount of time, right, these are brief interactions, build a bit of rapport with the person who's calling, understand what they're calling about, provide, do some problem solving, and then sort of wrap it up and document. So, those sort of rough stages of a call, they're doing risk assessment with respect to suicidality and homicidality, and then they have to understand active listening, problem solving, how to build coping skills, give folks some tools to manage stress or whatever distress they're experiencing. And then referral, if that's something

that the person's interested in, helping them connect to local resources that meet their needs, and documenting that in the case record system. So, it's building those skills.

CHAIRPERSON CABÁN: I have a question about referral, because you mentioned that this is a nationwide network. Somebody who picks up the 9-8-8 call that calls from New York City might actually get on the phone with somebody who is located out of state, and my understanding is that if you, luck of the draw, happen to have somebody out of state pick up the phone, that that person may not then, by virtue of being out of the state, make a referral to certain programs because of that. Can you talk a little bit about that?

ASSISTANT COMMISSIONER NECKLES: Sure. So, I don't think that's how it's operating here. So, the calls from New York City, based on cell phone routing, most people are calling from a cell phone or texting or chatting. There are landlines, too. So, they're routed to the counselors that are New York City based. And there are overflow plans in place. If, for example, there's a surge in calls, if 100 calls come in in a 20-minute period, right, for some

unknown reason, there's an overflow, and the overflow in our city goes to a Long Island-based call center.

CHAIRPERSON CABÁN: Okay.

ASSISTANT COMMISSIONER NECKLES: And so, that's a sort of a fail-safe. Also if there's, like, during Hurricane Sandy, back then, there were the call center problems, right, so there's some fail-safes, but the next tier is just outside of the city.

Most of the people who call, though, are actually looking for in-the-moment support. The number of folks who are interested in referrals is low. Most people want somebody to listen and support them through a period of distress. And then if there's referrals, we offer folks up to three referrals that meet their needs, things like language, insurance, level of care.

CHAIRPERSON CABÁN: Yeah, no. I think that makes sense. I know it's probably, I think the range is somewhere in the, like, 80 to 85 percent range where people are looking for that conversation and don't necessarily need the referral. But then that other percentage of folks who do need the referral, you know, it's a pretty acute need. And I guess,

yeah, when you talk about that overflow, I understand that the goal is to get a New York City-based person on the line with the caller. But there are times, to your point, that they are routed to an out-of-state operator. And so, like, I guess, what is the protocol to ensure that if they're a part of that subset who they need a referral, like, what's the protocol that ensures they can still be connected to a local crisis team?

ASSISTANT COMMISSIONER NECKLES: Sure. So, it's mostly, the fail-safe is out of city, not necessarily out of state, right? So, there's the Long Island backup, or we have counterparts on Long Island, and they'll answer it. And then I think there may be a third, you know, like, option which could also be out of state for some reason. But these are low occurrences. Most often people are reaching a New York City-based counselor. If, let's say it goes to a Long Island team, they can then reconnect back to New York City if for some reason there's a mobile crisis referral that's needed, which is very specific to how our City operates.

CHAIRPERSON CABÁN: Yeah. And I recognize the challenges and the capacity issues, and certainly

I think lots of folks here support sort of, like, the beefing up of the capacity of the 9-8-8 system and beyond, and I know that you know this, but to state it for the record, like, that low occurrence is still a human being seeking care. And, you know, we've heard some of the worst stories about what happens when a person, that one person is unable to get that care so certainly, like, endeavoring to make sure that we're not letting anybody fall through the cracks.

So, what does the handoff look like? Like, let's say you're part of that subset of people who does want, need a referral. How does 9-8-8 connect them to the services, or does the person have to then, like, follow up themselves? What does the handoff look like?

ASSISTANT COMMISSIONER NECKLES: So, it depends on the type of service that the person's interested in. The most common scenario would be a person who's interested in mental health counseling therapy, right? They want to go to a mental health clinic, of which there are more than 200 licensed mental health clinics in our city. The 9-8-8 protocol is to offer people three referrals, right? That's

ideal. Giving them the, like I said earlier, clinics that meet their parameters, and this is just one example, clinic. They will offer, if the person's interested, for a warm transfer to that clinic, if it's open at that time, right? They can't transfer to somebody to a clinic that's not open at the moment, but they will offer that. I think most people say, you know, just give me the information, I'll call when I'm ready. I think people have a limited amount of time on the phone, often want to think about it. Sometimes there's ambivalence about a person's willingness or interest in following through. So, they'll get the information over the phone.

CHAIRPERSON CABÁN: If, let's say, it's not open, and the person is going to do it when they're ready, or whatever it is, is there a protocol for just being like, hey, we're checking in, how are you? Did you reach out to this thing?

ASSISTANT COMMISSIONER NECKLES: There is a protocol. People are offered follow-up contacts, and may accept it, right? It's offered on a voluntary basis. Not that many people accept it, and of the people that do accept it, most don't pick up the phone when they call out, right? We know we get lots

of calls on our phones right now, and most people don't answer them. That's just the reality.

CHAIRPERSON CABÁN: The spam.

ASSISTANT COMMISSIONER NECKLES: Yeah.

CHAIRPERSON CABÁN: It's hard. We get too much spam, so we don't pick up calls.

ASSISTANT COMMISSIONER NECKLES: It's frustrating. But the good news is that it's open 24/7/365, and so people call back, and we know people call back and use 9-8-8 more than once. That's not uncommon. But there is follow-up offered, and we can provide the information over the phone. If you want me to send you the clinic information over text, we can text it so that you don't have to jot down the name of the clinic and the phone number, or send it via email. So, there's a couple options, so people don't have to write it all down in the phone call.

CHAIRPERSON CABÁN: Okay. Thank you. I'm just going to go back to those call takers for a second, and we talked about the training. But are they also, I'm assuming, I mean, is it correct that they are also trained specifically on just some of the mental health services that are kind of unique to New York City? So, like specifically our crisis

respite centers, our mental health clubhouses, our youth mental health clubhouses, like those things?

ASSISTANT COMMISSIONER NECKLES: Yes.

CHAIRPERSON CABÁN: Great. Thank you.

Okay. Could you go into a little bit more detail on, for the different kinds of interactions that you have with a call taker, how a crisis contact is resolved? You talked about what happens when, you know, it's deemed appropriate to like make a referral, but can you just talk about, you know, what follow-up after a crisis contact or maybe a referral wasn't something that, when it was a situation where the person was helped through their crisis, maybe they were able to like have their nervous system kind of recalibrate, whatever it might be and then, you know, how is DOHMH tracking the longer-term outcomes for individuals who call?

ASSISTANT COMMISSIONER NECKLES: Yeah. So, we wouldn't refer a person in crisis to a clinic, right, so I want to be clear. Those are for non-crisis situations, for sort of routine care, so routine. So, if there is an urgency to the person's mental health situation and they're unable or unwilling to get themselves to care, some people may

say like, well, I have a therapist actually, like, okay, I'm going to call them right now, right? That's a great plan, calling somebody you know, we're thrilled with that. If they're unable or unwilling to get to some sort of a treatment provider, 9-8-8 will dispatch a mobile crisis team. So, we use the word dispatch, it's more than a referral, right? We're not giving them a phone number and saying, you know, here you go, you can do what you like. The 9-8-8 is collecting information, right, and giving that sort of assignment to the mobile crisis team that, first of all, covers the age, right, so we have child-focused and adult-focused mobile crisis teams, and the neighborhood, right, and there's some overlap in neighborhoods for redundancy so that we have capacity. And they'll make that assignment to a mobile crisis team that will get out. Our average response time is just under two hours citywide right now, which is fantastic. They operate seven days a week, 8 a.m. to 8 p.m., and so they are going out and providing in-person services, and those mobile crisis teams then are the ones who are reporting back to the Health Department on the outcomes of their intervention. So, that is not coming from 9-8-8, who

has sort of a telephonic and finite, you know, period or limited period of time with the person on the call. The outcome is coming from the mobile crisis provider themselves.

CHAIRPERSON CABÁN: Thank you. I want to go just back to a second for the call takers and the training. Obviously, there are also instances, you know, people are calling about mental health challenges, dual diagnoses is obviously a thing, there may be folks who are navigating mental health challenges while also navigating substance use. How are 9-8-8 operators trained to integrate harm reduction principles into their responses, if at all? So, like, the things that are beyond just, like, hey, can we talk about a detox center or something like that, but just safe use, safe consumption, and some of the other things that we talk about in harm reduction, and does the current referral process include harm reduction services beyond outpatient detox?

ASSISTANT COMMISSIONER NECKLES: Yes. So, 9-8-8 is referring to the full array of substance use harm reduction and treatment services, not just detox, I think.

CHAIRPERSON CABÁN: Do you have some examples of what those are?

ASSISTANT COMMISSIONER NECKLES: Sure. Yeah. So, for example, naloxone and opioid overdose prevention providers, we've made sure to give the sort of updated directory of those that, you know, are developed by my colleague, Dr. Linn-Walton, to make sure they're incorporated into the 9-8-8 directory so that the counselors can make those referrals.

CHAIRPERSON CABÁN: Great. And is it part of their, I guess, do you have a sense of how deep or what the breadth of the training specifically on harm reduction principles and treatments are for call takers?

ASSISTANT COMMISSIONER NECKLES: Yeah. A harm reduction approach is the standard of care, like, it is what we do everywhere, and so it's built into it for substance use as well as other, you know, situations. It's not just limited to substance use, so that's expected across all of our programs.

CHAIRPERSON CABÁN: Great. And when 9-8-8 determines someone needs emergency services or involuntary transport, what's the protocol for

determining law enforcement involvement, and how is DOHMH working to minimize unnecessary police contact in those situations?

ASSISTANT COMMISSIONER NECKLES: Yeah. So, the entire approach for 9-8-8 is to provide, I don't love the term, but it's important, like, the least restrictive option, right, so that is their default training, that's part of the training that the new counselors receive, and so they're always looking for the least restrictive intervention, and often that's telephonic, like I said, just providing that in-the-moment support. They're assessing for risk in terms of a person's thoughts of hurting themselves or others, any plans to do so or means to do so. If they assess that risk, a person to have sort of thoughts about hurting themselves or somebody else and a plan, right, more than a thought, because sadly, you know, suicidal thoughts are not entirely uncommon among humans, right, life is difficult, and so I think just having a suicidal thought is not a reason to transfer someone for emergency response, but if, upon further probing, there is a concern about safety, imminent safety, they will engage emergency services. That's done infrequently, and typically, you know, the

counselor will remain on the call with the person, and their colleague or supervisor will engage 9-1-1 for emergency response. They are not making decisions about removal. Those are made by clinicians on site.

CHAIRPERSON CABÁN: Right. And I think, you know, I appreciate you talking about sort of the protocol being least restrictive. I think it's worth also mentioning that, I assume it's correct that also the part of that protocol is like, it's not just because it's least restrictive, it's least violent, it's least traumatizing, and because those things, when not absolutely necessary, are actually associated with worse outcomes, whether it's increase of risk of overdose later on, increase of risk of suicide attempt later on, or just simply the studies and data that shows that there are negligible differences between the outcomes of inpatient treatment and outpatient treatment, right. Sorry. I just want to make sure that's like part of the hearing record, but does that sound like about right?

ASSISTANT COMMISSIONER NECKLES: So, the outcomes of inpatient treatment, I don't think there's evidence comparing the outcomes of inpatient mental health treatment with outpatient treatment.

CHAIRPERSON CABÁN: Well, substance use. Yeah. There are for substance.

ASSISTANT COMMISSIONER NECKLES: Oh, substance use. Yeah. I think that would be a Dr. Linn-Walton question, that body of literature.

CHAIRPERSON CABÁN: Is that a fair characterization?

DEPUTY EXECUTIVE DIRECTOR DR. LINN-WALTON: So, I would say that when you include medication for addiction, the outcomes are tremendously good. A lot of our models, and I would say outside of New York City, much more of our treatment in New York City is outpatient than inpatient, so we really focus on outpatient and getting people medication the day that people are accessing, also through harm reduction programs, because we know a lot of people may, I've worked with many people who may have been kicked out of 10 programs over the course of their lifetime, and understandably don't want to go back to that same setting, and so we make sure that there's a full continuum. So, I would say that when good practices are in place, treatment is incredibly effective, and

it can be incredibly effective inpatient, outpatient, and in the harm reduction programs as well.

CHAIRPERSON CABÁN: Right, yeah. Well, and that was my point, sort of like if we're going to go with least restrictive, most autonomous, right, when it's good treatment, there are negligible difference in terms of outcomes for inpatient and outpatient.

DEPUTY EXECUTIVE DIRECTOR DR. LINN-WALTON: I think it depends on what the need is, though. For example, if you're detoxing from barbiturates, you definitely need some higher level care. That's why we --

CHAIRPERSON CABÁN: Yeah (INAUDIBLE) because that is a health danger in terms of you can't be left unattended, because you need a medical professional to navigate you through that.

DEPUTY EXECUTIVE DIRECTOR DR. LINN-WALTON: Yeah.

CHAIRPERSON CABÁN: For sure. Thank you.

What happens when a member of the public calls 9-8-8 on behalf of an individual who appears to be in mental health distress in the community, versus calling 9-1-1, and what's your suggestion for folks? Should they do that?

ASSISTANT COMMISSIONER NECKLES: Yeah. Humans should care for one another. When you call 9-1-1, you get police, fire, or ambulance. When you call 9-8-8, you speak to a crisis counselor. So, if you want to talk to a crisis counselor, call 9-8-8.

CHAIRPERSON CABÁN: Yeah. And, you know, we've talked to a lot of different community members as part of projects doing surveys with small businesses, with neighbors, and they really do want to know how to help their neighbors and don't know anywhere else to call but 9-1-1. And then I think, and we'll probably go into this more, and this goes to Council Member Lee's bill as well, is that a part of the problem, too, and part of the education of not just knowing about 9-8-8 is knowing how to be a good reporter. When I went to Portland to check out the street response team there, I got to stand in dispatch just to hear how they were taking calls, and like I had heard from and read in different reports about how the dispatch system, and now I'm talking about a 9-1-1 call for an alternative, but how there are so many problems with it in terms of the coding and all this. But then after talking to the call takers, it was actually much deeper than that and

something that can't be accounted for just in terms of codes. It's like, well, we have a legal mandate to take the information as it's described to us and the people who are describing are not the best reporters or they don't characterize behavior in a way that allows us to do the thing. And so I just, yeah, I think that continues to be an incredibly important thing in addition to people knowing about 9-8-8 is knowing how to talk about people who are in crisis.

ASSISTANT COMMISSIONER NECKLES: I think that's an important point. I think there's some distinction, right? 9-1-1 is taking callers at face value, whatever they're saying, they're not probing further. The volume is high and they need to move through those calls quickly for emergency services. 9-8-8 counselors are probing, they're listening, asking open-ended questions so, I don't expect a New Yorker to know how to make a good 9-8-8 call. I would never put the burden on the public to know how to make the call. That's the counselor's responsibility is to ask the questions to get the information that's needed.

CHAIRPERSON CABÁN: No. I hear that. That makes sense. I also, I think, as somebody who lives

with a mental health diagnosis and loves a lot of people with a mental health diagnosis, I would just, while it might not be my burden, I want to have more tools in my toolbox. I want my neighbors who care for me to have more tools in their toolbox when trying to get me help and, yeah, I think that's a really good thing to build that muscle as a community and if government can help with that even better.

Actually, I'm going to turn it over to -- oh, did she leave? Do you have questions? Yeah, go for it.

COUNCIL MEMBER ALDEBOL: (INAUDIBLE) I have a question about the mobile crisis team and you operate between 8 a.m. and 8 p.m. What happens in that 12-hour gap? And, you know, is there a plan to extend those hours beyond 8 p.m.? Because as you know, a mental health crisis can happen at any time, any day. So, that's basically my question.

CHAIRPERSON CABÁN: And what do you need to be able to operate?

COUNCIL MEMBER ALDEBOL: Right.

ASSISTANT COMMISSIONER NECKLES: Yeah. This is an important question and one we've thought about a lot. And in fact, we went through a

procurement process in 2019 just before the pandemic in an attempt to procure overnight mobile crisis response. We didn't get any bidders. I think we got a lot of feedback from the provider community that even with the higher funding that we offered for overnight, there were concerns by providers about safety. They're typically, you know, people, two people traveling in their own vehicles, maybe in public transportation, getting into buildings, you know, going into apartments unaccompanied is a risk for them during the daytime, and they do great work, not from the client necessarily, just being out in the world, and so the providers were really concerned about safety. And we explored, you know, security with them. Didn't love that idea, but, you know, would that work? But we do see fewer calls coming in overnight. And so the 9-8-8 is open, right? They're providing the telephonic crisis counseling overnight and making a decision based on the services that are available at that time. Often the person may say, you know what, if I can be the first referral in the morning for the mobile crisis team, they get out there by 9 a.m., 8, 9 a.m. That's okay. It's going to be fine. If it feels like it's unmanageable in that

moment, they will be able to talk about going to a hospital. Our city has, I think, maybe about 15 comprehensive psychiatric emergency programs, right, robust site-based, hospital-based psychiatric treatment 24/7 in those CPEPs. People can take themselves there. I've walked into an emergency room. We can all take ourselves there. But if it's not if that's not going to happen, if they're not going to take themselves, then they will, you know, engage in emergency transport to the hospital, request, you know, the police or ambulance to respond overnight.

COUNCIL MEMBER ALDEBOL: Okay. Yeah. No, I mean, you know, I myself have been, you know, involved in a situation where, you know, a family member, you know, having a mental health crisis, unwilling to call 9-1-1 because did not want police intervention, person was uncooperative in terms of, you know, trying to talk them down from the crisis and getting them to a hospital. So, it just, you know, I just think that, you know, having a mobile crisis team that's available and also, you know, just the training that police officers and even EMTs receive is inadequate to deal with certain situations, and so that's my concern that, you know,

there's a 12-hour gap where someone could be in crisis. A neighbor, a family member, you know, may be calling to try to help that person and is unable to do so on their own and, you know, EMT and police intervention is not, you know, is much less than ideal in certain situations. So, you know, I just want to express that concern and if we could figure out a way to, you know, expand the services or even have, you know, crisis specialists embedded in NYPD or EMS, you know, the FDNY to make to help that those types of situations.

ASSISTANT COMMISSIONER NECKLES: Absolutely. I think we'd love to explore those options, right? We want to be --

CHAIRPERSON CABÁN: Thank you.

ASSISTANT COMMISSIONER NECKLES: We want to protect the safety of our staff and the people we serve, right, and find the best approach to do that.

COUNCIL MEMBER ALDEBOL: Thank you.

CHAIRPERSON CABÁN: Good? Okay. Thank you, Council Member.

I actually want to expand on that a little bit. You said that the falls call (sic) overnight, can you give a bit of a comparison in

terms of like the percentage of drop or just yes or anything?

ASSISTANT COMMISSIONER NECKLES: I think I'd have to get greater detail.

CHAIRPERSON CABÁN: Yeah. Could you follow up with that? I think that would be helpful. And, you know, I certainly understand the challenges around safety and things like that, and this is something I'll ask about a little later on, but I think that also has to do with sort of like career pipeline work and who feels comfortable being a street worker and who doesn't because it's not for everybody. You know, like I spoke to the founder of the Denver Star Program who is an EMT worker himself, and he said, you know, the big thing is making sure that we have a pipeline of people who want to do street work. I was a public defender. We work with social workers. They're forensic social workers. They want to write the reports. They want to do the interviews. They don't necessarily want to be doing street work. Like there are all of these different kinds of ways to practice the profession, and street work just isn't for everybody. Like you, you know, some folks are going to walk into a different neighborhood, a

different context, a different situation, and be uncomfortable, and some folks, we're good, right, and so like just what the work that it takes to be able to find those folks that are like built for that kind of work I think is incredibly important, and they exist.

ASSISTANT COMMISSIONER NECKLES: Yes. Yes. They're doing heroic work right now.

CHAIRPERSON CABÁN: Absolutely.

Okay. I guess how many calls to 9-8-8 result in a mobile crisis team dispatch, and what share of the dispatches successfully reach the individual in crisis, and sort of average response time? But I want to give a caveat here, because I actually am not always so concerned about the response time depending on the situation, and if it means that you get to avoid a police officer coming instead, and some of the numbers that I've seen is that even if the response is a little bit delayed, that there's not much different in the percentage of times that they're able to reach the person. So, I'm like, well, if you're going to -- I'm making up a number now -- if you get there within 20, 30 minutes, and the person is still there 30 percent of the time,

and also if you get there an hour later, hour and a half later, and still it's you're getting to the person 30 percent of the time, and it still means that you didn't get a police officer, I actually prefer -- there are difference of opinions on that. I'm like, yeah, okay, great, I'll go with that. So, I'm asking that question, but with that caveat. I'm just curious about what the numbers are.

ASSISTANT COMMISSIONER NECKLES: Yeah. So, I think you make important points. 9-8-8, it was about 9,000 mobile crisis referrals last year, or assignments, dispatches, I'm sorry, I'm using those words interchangeably, although I shouldn't. That represents about half of the volume that mobile crisis teams handle, because while half of their referrals come from 9-8-8, the other half come from within the hospital provider's own network. So, for example, if I'm Bellevue Outpatient Clinic, and I'm worried about my client because he left me an unusual voicemail, I will refer to my Bellevue mobile crisis team. I won't dial 9-8-8. That's why they have the same electronic health record. And in that case, the mobile crisis team has a lot more information about the person, because it's somebody that's in their

care, they have a health record, they may know their schedule, collateral context, and they may time their visit to be optimal. What does that mean? When the person will be home. Maybe when there's a family member there who's helpful. Or maybe when there's not a family member there who's not helpful. They're going to handle the timing based on their own -- they're going to triage that timing themselves. Whereas the 9-8-8 calls, we say these are all going to be -- you're going to get here as fast as you can, because you have generally less information than you would from within your hospital system. So, those are the ones that are averaging within two hours.

CHAIRPERSON CABÁN: Okay. Got it. Thank you.

I'm going to move over to SPOA. Who can submit a SPOA request? What information is required? And sort of walk us through what a referral submission actually looks like from start to finish.

ASSISTANT COMMISSIONER NECKLES: Oh, wow.

CHAIRPERSON CABÁN: Sorry. These are big questions.

ASSISTANT COMMISSIONER NECKLES: That's a lot of detail. Sure.

So, the Single Points of Access were established around the year 2000 by a Governor's initiative as ACT teams were growing statewide. The State was, you know, opening up new ACT teams and there was a recognition that there needed to be more coordination and organization within counties and the City of New York to centralize referrals and prioritize access. And so, the Single Point of Access was created at that time and has been operating ever since. Back then, it was just Care Coordination and ACT. Over the years, we've developed new subtypes of ACT, right, Forensic ACT, Shelter Partnered ACT. We developed IMT in New York City. We've doubled the capacity of SPOA accessible services in the last 10 years. It's grown substantially. SPOA is still, though, a subset of the larger mental health system. Most people get their mental healthcare from licensed clinics, of which we have many, and those are accessed sort of directly. But the SPOA pathway is typically for folks who have not engaged in clinic treatment and really need somebody to come out to them in their home and proactively engage them, either at the care coordination level or at the sort of whole treatment team level. So, both of those

options come in. Our referrals come about, let me look at the numbers, 58 percent of them come from hospitals, right, 30 percent from private hospitals, and 28 percent from Health and Hospitals network. So, that's the biggest single source of referrals as a part of a discharge plan from an inpatient stay.

CHAIRPERSON CABÁN: Yeah. Who else can refer, though? Obviously, we know Corrections can refer. My office has referred.

ASSISTANT COMMISSIONER NECKLES: Anybody can technically refer, right, can go into our system and complete an application. We're looking for also a psychosocial assessment or a psychiatric evaluation to say that this person, in fact, would benefit from this kind of care. But technically speaking, anybody can refer. Practically speaking, it's mostly coming from hospitals, state psychiatric centers, Department of Homeless Services, Correctional Health Services, outpatient treatment providers, right, who are stepping a person up, as well as supportive housing providers.

CHAIRPERSON CABÁN: Yeah. I'd be curious if you all are interested in sort of building out a plan with a metric or a goal being that you're seeing

more referrals from outside of the hospital setting. Like I said, we've done, just as a discreet example, we did, my office did like a survey of 200-plus small businesses about safety issues and what they're seeing, whatever, and they just like, they would be happy to do referrals if they sort of understood because they're seeing the same people every day or they're concerned about it. And, you know, the less people that are going, we just saw the nurses come back from being on strike, and the biggest thing was the safe staffing. Like you have people that are going into an emergency room, and the setting to which they're going into, especially if they're shuffled into like a psychiatric response department, is like, I mean it sucks. It puts everybody in a terrible position, and it's not like a therapeutic environment just because of so many of the, yeah, there's a lot of work to be done there. They need a lot more, Bellevue needs more money.

ASSISTANT COMMISSIONER NECKLES: If I could take a moment there just to sort of touch on that point about community members, right, making referrals. Absolutely, we can talk about that. I think that's also a reason, a driving force behind

our Connect Clinic pilot, right, where we've built these enhanced clinics that have a community engagement component, right, a full-time community liaison who's talking to local businesses and communities to help get the clinic sort of go bust out beyond its four walls and be sort of more of a resource to community, responsive to community needs around food insecurity, around, you know, child care, legal assistance, right, whatever it is that it's important to that. And that is also a great resource for local constituents, right, just general New Yorkers to connect with those, and that may be more achievable than, yeah.

CHAIRPERSON CABÁN: And anything we can do to be able to like take that information to our constituents, I think we'd be happy to do, so.

ASSISTANT COMMISSIONER NECKLES: Awesome.

CHAIRPERSON CABÁN: When a referral is submitted, like who reviews it and what's the criteria for determining eligibility, and how long does the review usually take?

ASSISTANT COMMISSIONER NECKLES: Sure. So, there's a team in my Bureau of Mental Health of clinicians that review these applications within two

business days. They're reviewing them very quickly and making a decision about, you know, level of care that's appropriate, looking at, you know, diagnosis and hospitalizations or incarcerations as well as, you know, what else has been tried previously.

CHAIRPERSON CABÁN: And what happens if a referral is denied? Is there an appeals process? Are there other options available?

ASSISTANT COMMISSIONER NECKLES: Yeah. So, I think the, we got 4,952 referrals last Fiscal Year. 4,654 people were connected to care, right? So the vast, vast, vast majority of folks are getting connected to care. And it may not always be the higher level of care, right? They may be connected to a care coordinator, as I mentioned, as an alternate level of care while awaiting a higher level of care. But the vast majority of folks are eligible and assigned to either a care coordinator or a treatment team.

CHAIRPERSON CABÁN: And let's say that the referral finds it appropriate to, like for an IMT or like an ACT team, but there's a waitlist. What happens during that period of time?

ASSISTANT COMMISSIONER NECKLES: Sure. So, they're offered the care coordination while awaiting the higher level of care. Some folks are also transferring between levels of care on that waitlist just in case if a person, you know, I live in Queens and I relocate to Brooklyn, I'll get online for a Brooklyn-based team. We wouldn't prioritize that, honestly. That person would be, we'd wait a bit because there's other folks with higher priority who are not connected to any care, right? We would assign those first. And so that's how we manage the wait list.

CHAIRPERSON CABÁN: Okay. Yeah, that's what I was going to ask. So, before I ask that question, one question I have is, I mean, this is like a bureaucracy thing. I mean, do you find that there's a challenge or a problem with, you know, you're getting referrals and you get a referral from a hospital and a shelter and DOC and they're for the same person? Like is that, how are y'all navigating -- like how is that reconciled?

ASSISTANT COMMISSIONER NECKLES: Sure. So, you're talking about the data deduplication. Woo-hoo, we could talk about that all day. That's a challenge.

I think the chances of that happening all at once are low, right? Because the person's in one place. It's going to be either Correctional Health Services doing a discharge plan.

CHAIRPERSON CABÁN: It's not going to be Correctional Health and a shelter.

ASSISTANT COMMISSIONER NECKLES: Yes, but the chances that that person maybe previously had been referred to SPOA and already had a record in their system, we would merge those records, right? So that we can see the full history.

CHAIRPERSON CABÁN: Yeah. And then, and this is something I came across as a defender trying to get my clients into programs. So, is there a gap in sort of referrals or people who are struggling in terms of having like a dual diagnosis? Because so often somebody gets a referral and they're like, on a lot of different fronts they're technically eligible and then the provider finds out, oh, this person has a dual diagnosis, we can't accommodate that, we can't handle that. Like, how often are we seeing that?

ASSISTANT COMMISSIONER NECKLES: Sure. So, the term dual diagnosis can be used for a number of co-occurring health and mental health and substance

use conditions. So, you may be referring to co-occurring mental illness and substance use. We also have co-occurring mental illness and developmental disabilities, right, and so there's a variety of things that we see. All of our SPOA accessible services will serve and provide care to people with co-occurring mental illness and substance use, right? That is never an exclusionary criteria. We have concerns about co-occurring mental illness and developmental disabilities. ACT is not a good level of care for those folks, and so that's a challenge. And so some of those folks will go towards IMT, right, based on maybe they have a developmental disability and substance use, for example, right? That wouldn't fit into the typical ACT bucket, but would make sense for IMT.

CHAIRPERSON CABÁN: But I guess my question beyond that is that, do you find that that's a pain point? Is there room for improvement in terms of some difficulty placing folks that fall into those categories?

ASSISTANT COMMISSIONER NECKLES: That fall into the co-occurring mental illness and substance use?

CHAIRPERSON CABÁN: Any co-occurring, like just in terms of the rate of being able to be placed and placed quickly on, you know, an appropriate team or connection.

ASSISTANT COMMISSIONER NECKLES: I think what we're seeing most, the bigger gaps, and one of the reasons we created IMT in 2016 is for unclear sort of neurological or cognitive conditions, things like traumatic brain injury from repeated falls, perhaps, or substance use or unknown causes or developmental disabilities, right? That group of people, their behaviors or symptoms may manifest as sort of mental health, but the etiology may be different, and so diagnosis is unclear. And so that's an emerging need. And a lot of those folks, that's why we created IMT, to fill that gap.

CHAIRPERSON CABÁN: Well, yeah. And just, again, for the record, in terms of like the IMT being the most flexible of the teams because you're not getting the Medicaid reimbursement and have access to just doing things a little bit differently. Is that like a fair characterization?

ASSISTANT COMMISSIONER NECKLES: Yes. And it's a slightly different group. It's not the sort of

neatly sort of packaged diagnoses. It's where things are more complicated or confusing. And they have the flexibility to say, hey, let's, you know, while you go to this TBI sort of program, we're going to stay with you, right, and we're not double billing in that case. It's okay.

CHAIRPERSON CABÁN: It makes sense.

Council Member, do you have, I'm just like, do you have any more questions? You just like tap me and let me know.

COUNCIL MEMBER ALDEBOL: I will.

CHAIRPERSON CABÁN: Okay. All right. Okay.

So I, yeah, yeah, yeah. I was going to skip that.

I'd love to ask a little more detail about IMT versus ACT versus SPACT versus FACT. It's like all the letters. Oh, do you want me to do that? Yeah. Okay. Wait. This is the boss over here. I got some. Thank you.

Before I do that, providers report that SPOA sometimes assigns individuals to teams in the wrong borough. And you talked to us too about also the other occurrence where like if somebody moves. But like also if they are, they start their contact

in one borough, they get assigned in another borough, and that results in longer waits while individuals get reassigned or force individuals to start care with one team and then transition to a second team, raising concerns about continuity. Are there processes that you're looking into to better assign individuals to the appropriate teams at the onset? Or is that just simply a capacity thing where you like got to scale?

ASSISTANT COMMISSIONER NECKLES: Yeah. What's your assessment of that? So I mean, first, tell those providers to call me. We can talk. I don't know exactly what -- I haven't heard about that complaint specifically. I can say for sure that SPOA is working to get a person connected to the team that covers where they live. People move, and it's possible that they moved. I'm not sure that that's not a systemic issue.

CHAIRPERSON CABÁN: I will say it's something that's been brought to us several times by CASES. So, I think that might be a good place to start, touching base with CASES, because I don't think they're talking about like when an individual

moves, but just simply when they're being connected to care and it's in another location.

Okay. Now I will go over to the other teams. But I think you guys talked through the differences between IMT and ACT, so I won't ask that. But if somebody qualifies for both IMT and ACT, who decides which program they go to and on what basis?

ASSISTANT COMMISSIONER NECKLES: Sure. So, there's a clinician at the single point of access who's looking at the person's information and the referral source. They may speak with the referral source or somebody who's in contact with the person and figure out what makes the most sense. It's maybe about availability. And typically, right, IMT is there's fewer spots of IMT than there is for ACT. And so, if a person qualifies for both IMT and ACT, I think we would default towards ACT. Yeah.

CHAIRPERSON CABÁN: Yeah. Okay. So, it's based on capacity, not necessarily where like a designation on like actually this would be the most appropriate?

ASSISTANT COMMISSIONER NECKLES: I mean, it's really hard to answer that. I mean, they're going to make the most appropriate service. There is

certainly an overlap in eligibility criteria between ACT and IMT. There's a bit of a Venn diagram in those folks. I mean, you're going to make an individual decision.

CHAIRPERSON CABÁN: To be clear, I'm just trying to make the record that you guys need way more resources.

ASSISTANT COMMISSIONER NECKLES: I'm always pleased to make that point.

CHAIRPERSON CABÁN: Okay. For SPACT, for people who are shelter system involved, can you talk a little bit about what's different about serving someone in shelter versus in the community and specifically how SPACT like adapts to that setting?

ASSISTANT COMMISSIONER NECKLES: Sure. So the Shelter Partnered ACT teams are licensed by New York State, and they're actually contracted by New York State, but they're accessed through our SPOA, and so I don't want to take responsibility of those teams, but I certainly do know a lot about them because they're sort of a part of our healthcare system, and we work so closely with the State. And they have relationships with the mental health shelters with which they work, which are important,

right, because shelters are closed, right? Not just anybody can walk into a shelter.

CHAIRPERSON CABÁN: Right.

ASSISTANT COMMISSIONER NECKLES: And there's also, right, the person -- certainly people who are experiencing homelessness are served across our healthcare system, but it's like 100 percent of that Shelter Partnered ACT team so a focus of their work is housing placement as well so they have the resources and relationships to get into shelter and to focus on the housing placement in addition to the standard ACT package of mental health and substance use-related services.

CHAIRPERSON CABÁN: Thank you. I want to talk a little bit about justice-involved folks. So, for a FACT team, like at what stage of criminal legal system involvement is FACT referral appropriate? Is it pretrial? Is it post-conviction? Is it re-entry? Is it all of the above? Is it we're trying to get in there as early as we possibly can?

ASSISTANT COMMISSIONER NECKLES: All of the above, right? Any sort of criminal legal involvement coming out of state prison, out of local

jails, on probation and parole, right, or in some sort of a diversion program. It's a broad definition.

CHAIRPERSON CABÁN: So, if we want to try to do it at like the earliest possible juncture, one of the most critical parts of criminal legal system involvement is the arraignment, right, because that's when the judge is going to make a determination as to whether a person is incarcerated pretrial or not, and is there any possibility of being able to have even, like, short preassessments in arraignments so that an attorney advocating for somebody is able to say, like, hey, this person qualifies. Like, we can get them on a list for a team. That's a reason to release them out into the community. I know that, you know, attorneys are doing that for a host of other things, whether it's cases that's in arraignments that day or another provider. But I'm curious if you see that as being possible or something that can be worked towards.

ASSISTANT COMMISSIONER NECKLES: Yeah. I mean, I can say that the Health Department is standing up a mental health navigator program connected to the courts in partnership with the State Office of Mental Health. I think that program is

still sort of getting off the ground. And they will focus on that sort of situation that you're talking about.

CHAIRPERSON CABÁN: Yeah. I mean, that moment where bail is set is, like, the most disruptive in terms of any sort of connection or continuity of care. And then, you know, we also know what's happening inside of Rikers to folks who are struggling with these issues.

Yeah. Okay. Oh, yeah. We can do that.

According to the State Office of Mental Health's data, many ACT teams in New York City are operating at 90 to 100 percent capacity or above. What's the plan to expand capacity to meet demand, and are there plans to contract additional teams? Those are good numbers. We want more.

ASSISTANT COMMISSIONER NECKLES: Yeah. So, yes, as I said, the capacity for mobile treatment services, including ACT, FACT, SPACT, and IMT, has doubled since 2016. Most recently, right, the two FACT teams opened up, so that's new Forensic ACT capacity through State RFP, right, but those were accessible through our Single Point of Access in the city. The State also did a procurement for FLEX ACT

teams to address the issue of step-down from ACT, and so there's four that were awarded in the city. A typical ACT team has a capacity of 68 people. These FLEX ACT teams go up to 100, with those extra sort of 32 people being sort of folks who maybe get less frequent care, and so the idea is you can expand your caseload if you're seeing people a little bit less, and there's some more funding that comes in for that as well so that funding comes through us to those teams, so that capacity has already been added as well.

CHAIRPERSON CABÁN: And I think that's also part of the funding that we won last year in terms of being able to expand some of the step-downs.

ASSISTANT COMMISSIONER NECKLES: Yep, exactly.

CHAIRPERSON CABÁN: Okay. I want to talk a little bit about racial disparities. The ACT data is showing that 55 percent of participants are Black, and so I'm wondering what culturally responsive practices are teams using? How is DOHMH ensuring that those practices are consistently implemented? And then not just that, but also, you know, what is the

training, the cultural competency for also like trans and gender-expansive folks?

ASSISTANT COMMISSIONER NECKLES: Yeah. So, we see an over-representation of Black and Hispanic New Yorkers across all of our adult mental health services, typically up to about 75 percent of folks identifying as Black or Hispanic in our care, and so what is driving that, right? And we look at the upstream referral sources and the disparities in inpatient hospitalizations by race are similar. Racial justice and health equity are sort of core components of all of our work. We have a number of collaboratives with our providers to talk about how they can promote racial justice and health equity within their programs. We released guidance a couple years ago including, you know, things that organizations can do to address the work in terms of board representation and pay parity, and then also trainings for race-conscious and trauma-informed care at the point of delivery, and then, of course, looking at outcomes as well to see if those disparities exist at outcomes.

CHAIRPERSON CABÁN: Thank you. We'll move over to B-HEARD, and then we'll go to the next panel and following that, a public testimony.

You know, Council Member Schulman isn't here anymore. I appreciate the work that you're doing. I want to push a little bit, though, on sort of the concerns around increasing reporting because – and to put this into context, right? Like, there are a lot of things that B-HEARD is doing well, and then there are obviously areas for improvement. You know, I know that our Colleagues are constantly talking about the percentage of calls that are eligible that get answered by B-HEARD, and, you know, while it might seem low on its face, it's actually in line with the national percentages of these other programs that are doing well and responding to as many as they are, and they're saying, like, we need to scale also. The difference is outcomes – they are. They're calling the police in less. They are making better connections, and that's, like, the where do we take people. I think B-HEARD will never be the success we want it to be unless we have more places to take people, period. But I will say that -- and the last time there was, like, that big multi-agency hearing

on B-HEARD, I had asked a lot of these questions. But in terms of data and being mindful of HIPAA and all those things, like, I've got, you know, the CAHOOTS quarterly report, the Portland Street Responses quarterly report, Denver Stars quarterly report. It's really long, and they're collecting a lot more data, and they're not violating people's HIPAA rights. And the data that they're collecting is allowing them to get better, more effective outcomes. Like, you know, we get the reports from B-HEARD, and they're, like, seven pages – seven pages long. I mean, this is the Denver Star program's report. And so I just want to push us because we are going to continue to sort of underperform in terms of outcomes if we don't start getting that data. Like, it's really, really critical. And so, I guess a question I have for you is, have you all looked at the data that these other programs are keeping and gone through each of the categories? And not just data on individuals, but, like, we're not even keeping good enough data on the geographic information. Like, where are the heat zones, the times of day, the breakdown of the types of calls? I don't think that there's anything precluding us from doing that, and we know, we see

it. Like, this is amazingly not a new thing anymore. So, many municipalities have this alternate responder. They're doing better than us. And I want us to do better, and I think data is a big part of that.

EXECUTIVE DIRECTOR GRANT: Yeah. Thank you for that. So, under the last Administration, our cadence for reporting data on B-HEARD was essentially kind of close to annually. We think we can do much better under this Administration. We think that we can make more data available. We 100 percent agree with the spirit of Intro. 722 to be able to report more data more frequently, potentially on a quarterly basis, and so we look forward to working through that and to being able to share and publish more data. I will say one of the complicating factors that we have here in New York City compared to a lot of these other programs, which we do have contact with, we speak to Denver Star.

CHAIRPERSON CABÁN: I know. I know.

EXECUTIVE DIRECTOR GRANT: Our 9-1-1 system is dually operated by NYPD and FDNY. And then B-HEARD introduces a third entity, which is H and H, which is why under this Administration we are deeply

focused on interagency coordination and really figuring out how to be able to bring agencies together to work more cohesively and be able to share information better.

CHAIRPERSON CABÁN: I believe we can do it.

EXECUTIVE DIRECTOR GRANT: I think so too.

CHAIRPERSON CABÁN: I mean, the challenges in different places are different, and they're adjusting them. They might be different than New York City, but it's no different the existence of a challenge of, say, a municipality that says, well, our responder isn't a city employee, and so that poses its own kinds of challenges. They're problem solving for different things too. And so, I just want to say that complete partners in that. We want to be at the table for that. I don't want to step on Council Member Schulman's toes in terms of her leading on this bill, but anything that we can do to help along with this, we're here for, I'm certainly here for. That's what I had for you.

Do you have a question?

COUNCIL MEMBER ALDEBOL: One question.

CHAIRPERSON CABÁN: Okay. Beautiful. And then you can end us. All right.

COUNCIL MEMBER ALDEBOL: Yeah. I just want to go back to the equity question and access and how are 9-8-8, IMT, and ACT services being made accessible to undocumented New Yorkers who fear naturally, especially nowadays, fear contact with government agencies?

EXECUTIVE DIRECTOR GRANT: Yeah. So, 9-8-8 is anonymous, largely, right? If there's a mobile crisis, we need some more information like your address so they can find you, but the vast majority of people who reach out to 9-8-8, as I mentioned earlier, are just getting that immediate telephonic response, and so their immigration status is not relevant to the call. They're able to access it as much as they want. Their distress may be related to their call, and we can talk about that, but they're not going to need to obviously demonstrate what their immigration status is to receive that service. It's available across the board.

And for our SPOA accessible services, those are all available to people with and without insurance. There is no insurance requirement or

documentation about ability to pay or immigration status that factors into our assignment.

COUNCIL MEMBER ALDEBOL: Yeah. I mean I think that accessibility also requires a level of education and dissemination of information to our communities. Many communities don't know that they could access 9-8-8 without fear of being singled out as being undocumented so, that's a big concern in many of our communities, and how do you address that?

ASSISTANT COMMISSIONER NECKLES: That's certainly something we can reflect in the campaigns that we're planning. Dr. Wright mentioned that we're planning 9-8-8 promotion campaigns, and that seems like an important focus population of at least some part of that public education effort. It's a good idea.

CHAIRPERSON CABÁN: Can you give any detail? Because that was mentioned in the testimony, too, of these campaigns you're planning over the next year. Are there any plans? What do they look like? What are they?

ASSISTANT COMMISSIONER NECKLES: There are plans. I can't give detail on them. Just because I'm not the comms expert, I was focused on the program.

CHAIRPERSON CABÁN: That's something that we would love to get follow-up on as well.

Awesome. Those are my questions for you guys. Thank you.

ASSISTANT COMMISSIONER NECKLES: Thank you.

CHAIRPERSON CABÁN: Yeah. Thanks. Can we take, like, two minutes?

We're going to take a two-minute break before moving to our next panel.

Are we good? All right. Welcome back.

COUNCIL MEMBER FELDER: (INAUDIBLE)

CHAIRPERSON CABÁN: No funny business. I don't have time for that. All right. Thank you, Council Member Felder.

Before moving to public testimony, we're going to hear from a panel of individuals from the Independent Budget Office so welcoming up Ed Dolan and Cassandra Stuart.

Hi. Welcome.

I hear you want to be sworn in. I dig it.

COMMITTEE COUNSEL: I will now administer the affirmation to the witnesses from the Independent Budget Office. Please raise your right hand.

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

INDEPENDENT BUDGET OFFICE PANELISTS: (INAUDIBLE)

COMMITTEE COUNSEL: Thank you. You may begin when ready.

LEAD POLICY ANALYST STUART: Good morning, Chair Cabán and Members of the Committee. I'm Cassandra Stuart, Lead Budget and Policy Analyst on Health at the New York City Independent Budget Office, IBO. I'm 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 29th 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 should 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 and Hospitals, H and 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, as far as eligibility, the number of calls deemed eligible for a B-HEARD response increased nine-fold between the first full quarter during which the program was operational and quarter three of Fiscal Year 2025, which is the last period that IBO has data for. While a greater share of calls has been deemed eligible for a B-HEARD response, consistently more than 40 percent since the third quarter of 2023, a declining share of eligible calls have been assigned a B-HEARD unit, down from nearly 80 percent at the beginning of the study period to 37 percent by the end.

In terms of response time and time spent on scene, IBO's analysis reveals that the 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, which is slightly faster than it was for B-HEARD units. B-HEARD teams typically spend a longer time on site than other teams responding to mental health calls, which indicates that they're taking a longer time 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.

With regard to 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. This was also true in 2025.

As the Mamdani Administration 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 geography served. Additionally, as there have been calls by Council Members and advocates to expand the program citywide and to extend hours of operation 24 hours a day, the CBO's report identifies operational challenges for consideration.

B-HEARD is still considered a pilot, though it's been operating for more than four years and currently serves approximately 40 percent 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 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 and H's sole control, factors such as call routing

without FDNY involvement, replacement of FDNY staffing, and contracting for emergency vehicles are all issues that will pose operational challenges if not addressed. Thank you for the opportunity to testify, and we're happy to answer any questions. Thank you.

CHAIRPERSON CABÁN: I think I'm just going to start. Also, I want to acknowledge that I do still see the Administration in the room, and so thank you for staying and listening to some testimony. It's appreciated.

I want to start where I ended, actually. I obviously pressed the Administration some on some of the concerns or hesitancy around collecting and compiling and publishing more data points. In your report, you point out some of the pain points, some of the areas of growth. Do you think that being able to get that data, analyze additional data, would help address some of these pain points and the efficacy of B-HEARD as a response system?

LEAD POLICY ANALYST STUART: That's a great question. I think it's important to be able to look back at the few years of the program that we have now, analyze data that we have on hand, and see

what's working and what's not working, and use that to inform how we go forward.

CHAIRPERSON CABÁN: And you mentioned that four years later, this is still a pilot. I think we've gotten to a place, and we have enough information to know that this should be a permanent part of our continuum of care, obviously with the goal being that B-HEARD is successful if they are, through their connections to care, not just reducing and getting somebody out of crisis in the moment, but that they're actually reducing the number of calls, as a result, reducing the number of calls that come in generally. Can you talk a little bit about the challenges that get posed in terms of when it isn't scaled properly because you started to touch on that, and I think that's important.

LEAD POLICY ANALYST STUART: Right. So, what we found in our research is that at the beginning of the pilot, in June of 2021, the program was launched in three police precincts, and there were two teams operating per shift, and currently, or at least as current as our data goes, there were nine teams operating per shift in 31 precincts, so we scaled the number of precincts that we're operating

in, and then the number of teams operating per shift didn't grow in accordance with that.

CHAIRPERSON CABÁN: Thank you. And I think something, I'm going to make an analogy here, and you can tell me if this sounds right to you, but one thing that has been said in the violence interruption space is that, to your point that you testified, is that we get good outcomes, and then what happens is they're asked to cover more turf with not more resources, or not the commensurate resources, so then you take a violence interruption group that reduces gun violence in their catchment area by 90 percent, but then you ask them to double their catchment area, and you give them 10 percent more resources, and now they're reducing gun violence 30 percent, which, saving lives, that's great, but it is undercutting the efficacy of the program, and then that's how things stay pilots, because you're like, wow, it's only part of the solution. Like, we're not getting the best results we can when we know actually we could be getting a lot better results if we do it properly. Do you think that that's sort of like a fair kind of analogy to make in terms of how we should think about B-HEARD being scaled?

LEAD POLICY ANALYST STUART: I think that mirrors what we have put forward in our testimony, and I think it's one of the considerations that we put forward in the report is that City officials need to consider what the appropriate level of staffing is going forward in order to meet the current level of demand, and if there's increased demand going forward, what that appropriate staffing level would be.

CHAIRPERSON CABÁN: And, I mean, the current staffing includes, you know, an EMT. I don't know how we're supposed to keep these folks when we don't pay them. We don't pay them, they don't stay. You know, EMT, as a workforce, spends all this time training up these folks, and then they lose them after three, after five years, and they go to another emergency response. When you talk about the challenges of being able to fully staff and then scale, do you see that as being part of the problem?

LEAD POLICY ANALYST STUART: In the report, we do give specific numbers as of the last Fiscal Year for how many social workers and how many EMTs are working with the program. So, at the end of Fiscal Year 2025, there were 34 EMTs working with the

program, and sometimes those EMTs do get lost to transfer to other departments, or they might find new work or something like that. We do discuss in the report the challenges that the City has had with hiring and retaining social workers, but we also note that the Health and Hospitals has made efforts to recruit and retain in the most recent year.

CHAIRPERSON CABÁN: Yeah. These folks are not getting paid enough to do this work, clearly.

Oh, y'all were way more successful at getting data out of these agencies than we have been. Because you were able to get, you said you conducted the analysis using the FDNY data from the beginning of the program in June 2021 through the end of March 2025. How long did it take you to compile this data? And did you have to go to different, how did you do it? Because we've been fighting to get this data.

LEAD POLICY ANALYST STUART: That's a great question. Truthfully, IBO is uniquely positioned in City government because it's baked into the City Charter that we can request and receive data from other City agencies. To answer the other part of your question, it did take about a year to pull it

all together, but we got there in the end and we did put out the report.

CHAIRPERSON CABÁN: Okay. That's helpful.

Is there anything else that you didn't get an opportunity to testify on that you think is worth putting on the record?

LEAD POLICY ANALYST STUART: No. I think we covered the high points, and I would encourage everyone to read the report because there's good data in there.

CHAIRPERSON CABÁN: Yeah. Absolutely. Thank you for the work that you're doing. Those are my questions. Thank you so much.

Okay. We're now going to open the hearing up for public testimony. I want to remind members of the public that this is a government proceeding. Decorum shall be observed at all times. As such, members of the public shall remain silent at all times.

The witness table is reserved for people who wish to testify. No video recording or photography is allowed from the witness table. Further, members of the public may not present audio or video recordings as testimony but may submit

transcripts of such recording to the Sergeant-at-Arms for inclusion in the hearing record.

And if you wish to speak at today's hearing, please fill out an appearance card with the Sergeant-at-Arms and wait to be recognized. When you're recognized, you will have three minutes to speak on today's oversight topic. If you have a written statement or additional written testimony you wish to submit for the record, please provide a copy of that testimony to the Sergeant-at-Arms. You may also email written testimony to testimony@council.nyc.gov within 72 hours of this hearing. Audio and video recordings will not be accepted.

And the other thing, too, is I know that this room isn't really designed for it and there are advocates here and people from organizations and you like to have a picture of you giving testimony. So, if you would like that, just like hand the Sergeant your phone, they'll hand it to me and I'll take that picture for you. I know, it's important. People got to see the work you're doing.

So, Panel One includes Benjamin Heller, Jordyn Rosenthal, Nadia Chait, and correct me if I

don’t pronounce your name correctly, Dr. Van Yu, and Danielle Regis.

And you can start in whatever order y'all want.

JORDYN ROSENTHAL: Hi, everyone. Thank you Chair Cabán and Committee Members for holding this important hearing about how New Yorkers get connected to mental healthcare and thank you to the Administration for staying. I really appreciate it.

So, my name is Jordyn Rosenthal, and I am a social worker, a peer, and the Director of Advocacy at Community Access and the lead organizer of CCIT NYC. I'm here today under my CA hat, and I'm going to talk about some feedback that I got when I spoke to our homeless mobile teams and housing directors about what they think is the most important thing for Council to understand, what investments they want to see, and what other changes they envision so really from this on the ground boots perspective of what they encounter and the problems. So, staff emphasized that emergency systems and coercive measures like AOT are overutilized and do not address the needs of community members who struggle with their mental health. They described consistent system failures to

support individuals who do not meet the criteria for longer term hospitalization but are hospitalized frequently and are already connected to ACT services. For some people, the lack of timely and comprehensive support services in times of crisis can put people at risk for interpersonal violence and behaviors that create fear and concern for other community members. When police are involved in these scenarios and bring individuals to the hospital, they're almost always discharged because it's a behavioral issue and not a mental health issue, or conversely, due to administration pressure in the hospital system and to reduce liability concerns in the discharge planning process, individuals are placed on AOT instead of connecting individuals to voluntary treatment and support options. In particular, when people are experiencing prolonged periods of crisis and threats or act of interpersonal violence or property destruction, community access has had multiple complex needs case conferences with the State and City, DOHMH, which have produced no answers or solutions for where these community members might be referred to for real assistance or a safe place to

live that will not endanger others in that environment.

So, when asked about what investments they want to see, they pointed to embedding higher levels of support and supportive housing. For example, funding interdisciplinary teams that could be deployed by housing providers so like an internal type of IMT team that you could end to all of your different supportive housing sites and kind of have it 24/7 and not have to rely on external actor. And including peers on these teams would be great value in terms of engagement and connection building. They highlighted the need for crisis response providers who can physically travel to meet people in their homes or places where they're comfortable. Supportive housing providers need access to more funds to have like multidisciplinary teams within their care including RNs and psychiatric nurse practitioners

(TIMER CHIME)

CHAIRPERSON CABÁN: (INAUDIBLE)

JORDYN ROSENTHAL: Okay. Thank you. This would serve aging-in-place and isolated community members by lowering barriers to access to care. In turn, this would reduce unnecessary emergency room

utilization, improve tenant health outcomes, and reduce mortality rates for already vulnerable populations. This sentiment was echoed by calls for expanding the IMC funding, specifically because it's not tied to Medicaid billing so that way you can get people more services so that's just preferred in that case. And then other suggested investments include lower density shelters, especially in the case of MICA shelters, the importance of decreasing wait times for mental health clinic access, and just the fact that people get discouraged when they have to wait longer so really, as you said before, the need for having third spaces and options for people to deal with crisis and be connected to care in a timely manner. Thank you.

CHAIRPERSON CABÁN: Thank you.

NADIA CHAIT: Hi. I'm Nadia Chait. I'm the Senior Director of Policy and Advocacy at CASES, and thank you, Chair Cabán, for this hearing. CASES is one of the city's largest providers of Intensive Mobile Treatment teams. We have nine Assertive Community Treatment teams including four forensic teams and two that serve as an alternative to incarceration, and we have seven Intensive Mobile

Treatment teams so we fully believe in the incredible value of these services and the work that they do to help New Yorkers live their lives stably in their communities with the supports that they need. A clear priority for the City in this budget has to be, as you've discussed, eliminating the waitlist for ACT and IMT. It remains unconscionable that we don't know the exact number, but some hundreds of New Yorkers are waiting for these services that they've been assessed to meet the need for, and I think often, and I think we didn't hear this today from the Administration, which is great, we've often heard, well, folks get care management while they're on the waitlist, but by virtue of qualifying for ACT or IMT, this is a person who needs a much higher level of care, and so really working to get folks into those services as rapidly as possible, and particularly making sure that folks who don't have an AOT order also have rapid access. And to that end, we also support the passage of legislation to require public reporting on the size of the waitlist so we have a better sense of the scope of that problem and how long individuals are on the waitlist and if there are any demographic disparities within that.

We also would like to see greater attention to reducing Medicaid disruptions, which can have a huge impact on people at critical times, both around hospital discharge and around release from incarceration. I'm optimistic with new leadership at DOC that we'll see more progress on this issue, but we've seen, particularly with our FACT teams, huge issues where people either actually are still having their Medicaid terminated, which should not be happening at all when people are on Rikers, or are coming to us with their Medicaid set to inpatient status, but without the appropriate documentation to allow us to get that status changed back to community, so their release paperwork is incomplete, they lack their vital documents, and often by the time we actually get that documentation, their Medicaid has become inactive, requiring an entirely new application. With IMT, that's not a barrier, because IMT isn't a Medicaid service, but with ACT, it can present some real challenges, both for us, but also for referring that person across the continuum of care.

And then the last thing I'll note is really on the workforce, and particularly with a

focus on peers and building the career ladder for peers. So, within IMT, we are actually able to fund peer supervision positions, which is really exciting for an agency like CASES that has a wide range of peers across our services, but we don't see that support for a career ladder for peers across the full continuum of services, and would like to see additional investments there. Thank you.

CHAIRPERSON CABÁN: Thank you. Look at that timing. That's good.

Plus cosign on peers. I do want to note that last budget cycle, the Progressive Caucus fought alongside community partners for the 15.5 million to expand the mobile mental health treatment teams and eliminate the waitlist, and so that is a question that I will be asking at the upcoming budget hearing to see how that money's being spent and what kind of progress we've made on it on that front. So, thank you.

BENJAMIN HELLER: Hello. Hi, Chair Cabán. Thank you for hosting today's hearing. Hi, everyone else. My name's Benjamin Heller, and I'm a Program Manager at the Vera Institute of Justice. Thank you for the opportunity to testify today.

Our City increasingly relies on the criminal legal system to respond to behavioral health needs, and this has contributed to the ballooning jail population, hindering the City's commitment to close Rikers Island by 2027. As of last Fiscal Year, roughly one in five people on Rikers Island had a serious mental health diagnosis. Police, courts, and jails do not provide effective treatment and incarceration often worsens mental health outcomes for individuals and for communities. To improve community-based mental health treatment, the City must start with three focus areas.

First, and you've heard this a lot already, assess and scale existing services. The numbers we have are from March 2025, where the IMT waitlist was 672 people, and the ACT waitlist was 682 people. City Council must pass legislation requiring DOHMH to regularly report on these waitlists, 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.

Second, send trained peer specialists and clinicians to mental health crises, not police. Again, you've heard about this today. B-HEARD's call triage limitations and narrow eligibility criteria have meant that in the third quarter of 2025, only 41 percent of "emotionally disturbed person," or EDP, calls were deemed eligible for a B-HEARD response. To close this gap, the City should update 9-1-1 triage and dispatch to make more EDP calls, including, importantly, instances of self-harm eligible for B-HEARD. Police should not be dispatched before EMS has the 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.

And third, grow the behavioral health workforce. The City should mobilize a comprehensive behavioral workforce development strategy, leveraging existing assets like Health and Hospitals Peer

Academy, Community Access' Howie the Harp, and other initiatives run by OCMH. This will enable the City to scale up mental health services to meet increasing need. And without it, even with adequate funding, services won't scale.

Voluntary community-based mental health services make our communities safer. By expanding and strengthening these services, the City can support people before a crisis pushes them into the criminal legal system. Incarceration cannot meet people's mental health needs, let alone do so with dignity or compassion. Thank you.

CHAIRPERSON CABÁN: Thank you.

DANIELLE REGIS: Good afternoon. 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. Chair Cabán and Members of the Committee on Mental Health and Substance Use, thank you for the opportunity to testify today on the critical issue of New Yorkers' access to crisis mental healthcare.

As a public defender, I have represented people in Brooklyn's mental health court for approximately eight years, and this month marks my

15th year as a public defender. The people I represent often encounter police when they are in crisis and seeking care, or when the absence of available care has 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. 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. Mental health crises must be treated as health issues, not law enforcement matters. People seeking emergency mental healthcare must be met with the compassionate and immediate care to avoid escalation and possibly arrest. I would like to highlight several urgent issues that will help ensure greater access to care for people living with mental illness. We address these concerns in greater detail in our written testimony.

First, New York City 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 healthcare is often impossible. For many of the people that I represent, connection to stable housing has been life-saving. Basic stability allows meaningful engagement in care, but access to supportive housing should not depend on criminal legal system involvement.

Second, we must expand low-cost mental health and substance use treatment. Many of the people we represent have tried for years to access appropriate care but face significant barriers. For people with co-occurring serious mental illness and substance use needs, there is currently only one long-term inpatient treatment facility in New York City that actually accepts Medicaid. As a result, many people remain detained on Rikers Island awaiting a treatment bed. Jails should not function as a waiting room for care. We need a full continuum of treatment options for people who are ready to engage in care.

Finally, we urge the Council to support the Treatment Court Expansion Act. Judges currently have discretion to divert cases involving substance use disorders, but diversion for people with serious mental illness often requires prosecutorial consent.

This leaves many individuals in traditional court where their conditions worsen. This bill would expand eligibility to people with other mental illnesses, developmental disabilities, and cognitive impairments that can be effectively addressed through treatment. Thank you for your time and attention.

CHAIRPERSON CABÁN: Thank you.

DR. VAN YU: Good afternoon. Chairperson Cabán and other Members of the Committee, we thank you for this opportunity to testify. I'm Van Yu, the Chief Medical Officer of the Center for Urban Community Services, CUCS, whose services include mental healthcare via mobile teams, including City-funded street outreach and Intensive Mobile Treatment teams and State-funded Safe Option Support teams. I'm here to advocate for measures to enhance the effectiveness of Intensive Mobile Treatment teams, IMT.

A significant proportion of New Yorkers with acute mental health needs, especially people experiencing homelessness, not only face access barriers to care, but also encounter care in traditional healthcare settings that is not well-suited to their unique needs. Mobile teams not

only address access barriers, but also bring expert providers who operate with flexibility and creativity, allowing for painstaking relationship building and effective care. IMT was created to leverage this flexibility, creativity, and targeted expertise to serve people with the most complicated mental health conditions who have been failed by other systems. These ingredients have resulted in the great success of IMT. Last year, there was a 38 percent increase of CUCS IMT clients who became permanently housed. Furthermore, CUCS IMT psychiatrists are able to engage people in treatment at higher rates than achieved in more traditional healthcare settings. About 90 percent of clients referred to CUCS IMT psychiatrists remain engaged in care. About 50 percent of clients living with schizophrenia adhere to long-acting injectable antipsychotic medications, and about 50 percent of clients living with opiate use disorder engage in medication-assisted treatment. Although IMT has been very effective, there are, as you've heard, waitlists of people who could benefit from the service, but instead remain inadequately served and suffering. We encourage the City to move forward with plans to fund

additional IMT teams. We also encourage the City to consider ways to empower IMT teams to influence where people are placed in safe havens or shelters, as the ability to place people in familiar neighborhoods or close-to-care providers can significantly improve engagement. We also encourage the City to consider ways to prioritize IMT clients to safe haven and permanent supportive housing placement to reduce the time to housing for this most vulnerable population.

Finally, for the 10 years since IMT launched, CUCS has developed best practices that could support model fidelity and effectiveness across the team citywide. We therefore also recommend investment in a centralized IMT training at Technical Assistance Institute to promote shared learning, strengthen workforce capacity, and ensure consistent delivery of this high-impact model as it expands. Thank you for your attention and consideration.

CHAIRPERSON CABÁN: Great. Thank you.

I just wanted to kind of -- well, I guess I'll pose it as a question, be participatory. But in the Committee's report, there's a section sort of like on challenges and a subsection on the IMT teams, and it talked about the 2024 Comptroller audit. And

we were doing the briefing for this, and when I read it, I take notes, and I bring it to these folks who are smarter than I am, and we talk about it. And I think it's interesting because there sort of was, I guess it could be characterized as a criticism of IMT in terms of not being able to report specific outcomes or data points, and I actually don't think that that's really a problem when you get down to it for this. Like, we can talk all day long about how we need more data points for, B-HEARD for efficacy. But like, I just want to understand, at least have you talk a little bit about why sometimes that isn't the thing that should be measuring success, because the whole idea of IMT is to be nimble enough and provide an opportunity for creativity, not be bound by the things that you have to do when you're being reimbursed by Medicaid. So, I was actually critical of that portion of the Comptroller's audit, and just wondering if you have any suggestions in the face of that. Obviously, we come here and we talk about all these things, and we're like, prove it, prove it works, because we're putting taxpayer dollars into it, and sometimes it's not easy to put on paper, but the IMT is clearly filling a very unique gap and

doing it in a way that has less constraints, but probably is harder to report on.

DR. VAN YU: Yeah. I appreciate the question. I 100 percent agree with you. IMT is designed to serve the people who have the most complicated situations who have been failed everywhere else. So, you know, in line with that, I think, using like traditional measures of effectiveness outcome measurements, it's like not necessarily going to be appropriate. And even within an IMT team, you'll have 10 people for whom this set of criteria might make sense, but another 10 where it won't, right?

CHAIRPERSON CABÁN: Right, like what's success, right?

DR. VAN YU: What's success, right?

CHAIRPERSON CABÁN: Because based on the environment that they're living in, and like a societal structure that like does not sort of create the ability for people with mental health issues to like navigate the world the way like neurotypical people do, for example, of like success could mean a day-to-day life that looks different than somebody else that may have more challenges as a baseline, but

it's still a vast improvement from what they might otherwise be struggling with.

DR. VAN YU: Yeah, right, so I agree. I think just like the care and this engagement has to be unique for each individual person in this kind of setting, I think the definition for success is also necessarily going to be different for different people. You know, so it might require, instead of like a lot of quantitative measures that we're used to looking at, more qualitative kinds of measures, which, you know, are more difficult to assess, difficult to put together, but could also be more interesting also and like more impactful and more powerful. You know, and there are, I think, some standard measures that are still worth looking at in this population. For example, hospitalizations, right? Like you would definitely want an IMT team to decrease the numbers of hospitalizations that people had, you know, compared to prior to them joining IMT. So, there are a few measures that are definitely still worth keeping track of.

CHAIRPERSON CABÁN: Cool. Thank you.

NADIA CHAIT: If I can just quickly add to that. I think also when we think about measures, it's

important to consider what measures we as providers have control over and what we don't. So, I know in our IMT teams that the percentage of our clients who we've successfully connected to supportive housing has decreased in recent years. It's not because of a change in practice for our teams. It's because we're just finding that the length of time it takes to get a person into housing has significantly increased. I think that still makes it a valuable data point to connect.

CHAIRPERSON CABÁN: You can't hear, Council Member?

COUNCIL MEMBER FELDER: Just talk into (INAUDIBLE)

NADIA CHAIT: Yeah. Sorry about that. I was saying the length of time it takes to place someone into housing has increased. I think it's still a valuable data point to collect, but the outcome is not that provider isn't doing a good job. The outcome is we need to solve the systems behind which it takes so long to get someone of such high need into the housing that they deserve.

CHAIRPERSON CABÁN: What story are we telling or what conclusions are we drawing from a particular piece of data?

Great. Thank you.

JORDYN ROSENTHAL: And this might be a little floofy, but what about asking the person on IMT what do they consider success, right? I think a big part of what everyone has talked about is the need for voluntary services. And I recently saw this New York Times article that was about the cold and bringing people in, and someone wrote in the comments something that it was like a light bulb moment. And it just said autonomy. People want to make choices for themselves so, I think also empowering people, asking people what does success mean for you, right? So, instead of just having quantitative measures of, that also should be like, have you had engagement with a peer, right? Like how many peer interactions you've had? It doesn't need to be like, how many times have you seen Van or whoever. There are other alternative things. But I think asking people, it doesn't need to be like in a system, right? But asking people like --

CHAIRPERSON CABÁN: Like what do you want to be able to do in the course of your day?

JORDYN ROSENTHAL: What is your goal? And then if you want to quantify that, how many people made their goal, right? It could look a lot of different ways. But I think a part of this is also engaging people in their own care. And if we want people to accept voluntary services, we have to actually engage them and ask them what they want and what they need.

CHAIRPERSON CABÁN: Thank you. And thank you to the entire panel.

Oh, sorry. Sorry. I forgot you were there.

COUNCIL MEMBER FELDER: I forgot I was here as well.

CHAIRPERSON CABÁN: I know.

COUNCIL MEMBER FELDER: Yeah. This may be unconventional, but if you don't mind, no one has to raise their hand if they don't want to, but how many people in the audience that are willing to raise their hand that have a family member that has some of the issues that we talked about?

Okay. Yeah, yeah, yeah, yeah, yeah. No. So, I just wanted to comment is that I had to leave, so it's really not fair for me to comment, to the Zoning meeting, but I had a family member, may she rest in peace. It just seems to me, you know, and I have very, very strong memories, you know. First of all, the housing issue, there's so many different levels of people that are in need, just like, for example, I have Crohn's disease. There are people who have it severe, and different, you know, there are different levels of whatever it is, similarly. But if you have a family member or it's somebody who refuses to get help, you know, I understood the comment about what they want, but part of the disease is the distinction between Crohn's disease or anything else is that the, you know, the people who really are not well, unfortunately, they refuse to get help. That is part of the nature of the disease. I will just say to you is that for my family member, you know, she was on a list for not only having residence but for having the care. Having residence is important for someone who's not that sick and is okay with somebody, you know, being able to go, having a place to live, and being able to go on their own and get

help wherever they need to get help. But if, you know, somebody is very sick, you know, very sick, they had a space, you know, for her, and then they had a place where somebody would be coming in regularly, you know, on a daily basis, twice a day to see what was going on, whether she was taking her medication or whatever else. I'm just saying, just to, you know, to try to make it brief, I'm talking about as a 10-year-old, because I remember it distinctly, is that when she was not well, she refused to take her medication. I used to go into a room, lock the door. She was willing to take a sleeping pill to get sleep. I used to, in order for her to take, you know, the medication that she needed, the doctor said that it was more important that she take the medication, and then she'll be able to get the sleep. I used to, like, you know, some kind of a horror movie, which is what it felt like as a 10-year-old, I used to open the capsule. I had to peel off the peel, you know, of the thing, take out the capsule, empty it, crush the medication that she needed, put it in the capsule, put it back in there, and glue it perfectly shut as well as, to get her to take the medication. So, I'm just, you know, I don't

want to spend more time. I'm just saying that it, first of all, the City, you know, I'm just saying my opinion.

CHAIRPERSON CABÁN: Okay, 20 seconds, Council Member.

COUNCIL MEMBER FELDER: Yeah. You could buzz me. This is one of the areas that I would just say is that the City, it's impossible for any government to be able to do what needs to be done. The organizations in the neighborhood, they know what they're doing, and we need more of it. You mentioned more of it, and supervision. And in terms of asking the person what they want, obviously, you know, somebody who's sick can't do that.

CHAIRPERSON CABÁN: Thank you, Council Member.

I'm going to -- and I know Jordyn's going to have a lot to say about this. I think I want to engage with that a little bit. I think, you know, at least what I have learned is that a refusal is not a refusal on its face. And so, you know, you have to be able to provide options that are going to be responsive to. Like, you know, a person might not be able to get out the door to get to a program twice a

week, but they're going to be okay if you can get a team to their home, or a person might need a supportive housing setting, otherwise. Or maybe a person, you know, needs intravenous treatment versus being able to take pills. And so, I think, you know, while we can't solve for everything as a government, I do think that we probably can agree that there's a whole lot that we have not done yet. Like, the span of what we have not done is this big. And so, I certainly, you know, don't want to jump prematurely because we haven't done our job in making sure that we are providing as much choice and autonomy as possible. I think that's really important. And also, that people with SMIs live really, really productive lives. And, like, I'm talking about the intersection of what we consider really serious SMIs. There are people with schizophrenia. There are people with schizoaffective disorder. I mean, a few months ago, I was just reading The Collected Schizophrenias, right? Like, we're talking about people with, like, what we consider, or would assume, without more information, would be somebody who could not, quote-unquote, function in our communities, but can create communities, support systems, where, like, yeah,

there are periods of struggle, but also, there's incredible beauty in what they bring into our world. I found that book to be, among a bunch of other obvious, obviously, writings and stuff. But what do you think about this?

JORDYN ROSENTHAL: So, first, I want to actually introduce a new idea that I don't know if everyone knows about, but they're called PADS, or Psychiatric Advanced Directives. Can I just, like, does anyone, even in the audience, do people know what that is? Has anyone ever heard of it?

COUNCIL MEMBER FELDER: (INAUDIBLE)

JORDYN ROSENTHAL: Yeah. Oh, sorry. I'm sorry, I didn't mean to steal it.

CHAIRPERSON CABÁN: You have permission. Go for it.

JORDYN ROSENTHAL: I'm sorry. I wanted to, you know, sorry, gotcha. Anyway.

COUNCIL MEMBER FELDER: (INAUDIBLE)

JORDYN ROSENTHAL: You know, we only got so many jokes, right?

CHAIRPERSON CABÁN: But you could plan for it.

JORDYN ROSENTHAL: But anyway, yeah, so the point of the Psychiatric Advanced Directive is like a health advanced directive, right, and you work with your psychiatrist to basically create a plan that says, if X, Y, Z happens, this is what I want. This is how I want to be treated. This is who I want to respond. It is a legal document. It doesn't supersede everything. But I think there are ways to incorporate someone's voice. And I hear you about, you know, your experience, and, you know, the vastness of the issue, right? Like, it's not one size fits all. And I think that's what we're all saying, right? And I think that part of why it's so important to engage the person, even if we may disagree about cognizance, or insight on one's own mental health, is that we have to work together, right? And I think that, you know, we need to engage the person to say, you know, what do you think, right? And I'm going to just give a quick story of an example that everyone has heard. If you've ever heard me testify, I've probably told this story. But basically, I had met a woman who had left Bedford Hills, and she was sleeping out on the streets. She had, you know, PTSD, et cetera, whatever. She did not shower. Now, the

reason why she did not shower was because it was a means of self-defense. Now, the reason why I'm saying this, and why it's so important to engage with that person and talk to them, is because very often, we could, especially under this expanded AOT Kendra's Law order, we could say this person's not taking care of themselves. They reek of urine and feces, you know, blah, blah, blah. When in reality, she knew what she was doing. She was making a conscious effort to actually smell as bad as she could because she thought this will keep people from sexually assaulting me as I sleep. So, I think about this story all the time, because there are pits of information that we can get to that also build trust. So, for instance, if you had a peer responding to that person who had experience with unsheltered homelessness, they might know that from the get-go, and then they wouldn't have to ask that person questions about their cleanliness so it automatically builds this kind of foundation of trust and camaraderie, which puts you in a better position for someone accepting care. So, again, it isn't necessarily that it's like you're doing it for show or anything, but like actually engaging the person in

their health has better outcomes all around. So, thank you, and I appreciate your openness to my response.

CHAIRPERSON CABÁN: I also thank you, Council Member, because I think it really contributed to some good testimony and discussion.

And thank you to the panel.

Okay. Panel number two is Razia Begum, Sofina Tani, Kumari Cruz, Fiodhna O'Grady, and Jonathan Chung.

FIODHNA O'GRADY: Hello there. Good to see you again. And if I may, my Executive Director couldn't come, so I'm going to actually read her testimony, but I'm handing you both mine, and I'm orally reading hers.

CHAIRPERSON CABÁN: Got it.

FIODHNA O'GRADY: Thank you. I am Fiodhna O'Grady. I am the Government Relations Director for the Samaritans of New York. We provide a confidential and anonymous suicide prevention support for New Yorkers 24/7. As a role, we also serve, we have a seat on the National Council for Suicide Prevention, and work internationally with befrienders worldwide. There's over 400 branches of Samaritans in over 40

countries. It's the largest global suicide prevention network. We support all three items before you today. And again, I think I'm echoing what I'm hearing, and I'm glad it's in my black and white also, which is trust is what is at stake today, and trust depends on transparency. And at a minimum, the Council should have access to aggregate reporting on key 9-8-8 performance indicators. And also, they can do that without compromising confidentiality as it is already being collected. So, we're talking about the call text and chat volume, waiting times and call abandonment rates, cross-state routing and use of national backup centers, which you've all mentioned, risk levels identified during contacts, emergency dispatch and mobile crisis deployment, and referral patterns and the types of services callers are connected to. Transparency allows policy makers 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 a 9-8-8 and SPOA, it's also important to remember that suicide prevention does not occur only within

centralized intake systems. It happens across the broader health and the social service landscape, as well as, I think, demographics and the downstream issues that lead to crisis. Community organizations, healthcare providers, schools and local hotlines, they all play an important role in helping people reach support. When we become over-reliant on a single system, whether it's SPOA or 9-8-8, 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. These are different strengths. A well-functioning crisis system needs both. 9-8-8 may be the front door to crisis care, but that does not mean we should turn all (TIMER CHIME) the other lights off. And I'd also like to add that when you look at the best practices in suicide prevention, the Army and Navy did the best national research, and what they found was that autonomy and allowing the person who is either suicidal or has had attempts, et cetera, giving people choices amongst services worked. And that was the largest, because it is a closed cohort of people, it was the largest study, and basically what they're saying is diversity

of services and choices that persons can make in their autonomous self works best for suicide prevention.

KUMARI CRUZ: Good afternoon, Chairs Cabán and Members of the Committee. My name is Kumari Cruz, and I am Director of Bereavement and Public 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 all across New York City to strengthen suicide prevention education. From this perspective, I want to focus on something that Fiodhna mentioned and everyone else prior had mentioned, something that determines whether crisis systems actually work, which is trust. A crisis system only works if people trust it enough to reach out. For many people, that decision depends on whether they believe that they will maintain autonomy, whether their conversations will remain completely confidential, and whether seeking help could lead to consequences they didn't intend. New York City has made important commitments to least restrictive crisis response and to minimize unnecessary police involvement in behavioral health emergencies. From a suicide prevention perspective,

crisis intervention should prioritize autonomy, voluntary engagement, confidentiality, and harm reduction and least restrictive care. These principles matter because they directly influence whether people feel safe enough in asking for help. If people fear losing control when they reach out, they may not reach out at all. This concern is important for communities that have historically experienced harm with informal systems, including undocumented residents, LGBTQ-plus youth, and communities of color. Other important realities is that many people never enter crisis systems through formal entry points. They may reach out first to a trusted community organization, like Samaritans, healthcare provider, school counselor, or a local hotline. These trusted relationships often represent the moment when someone first feels safe enough to talk about what they're 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 much more likely to reach the support they need. Thank you.

RAZIA BEGUM: 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, also known as AAFSC. AAFSC provides linguistically accessible, trauma-informed, and multigenerational services across all five boroughs. While our doors are open to all New Yorkers, we have deep expertise serving Arab, Middle Eastern, North African, Muslim, and South Asian communities. With services offered in more than 20 languages, we support over 20,000 individuals each year. 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 9-1-1 and 9-8-8 systems. Over the past year alone, AAFSC has experienced a 54 percent increase in demand for mental health services. We see pervasive fear and anxiety, families delay seeking care, parents fear sending their children to school, community members

avoid medical services and hesitate to report violence or abuse. Anti-Asian hate, immigration enforcement policies, and ongoing federal uncertainty have intensified distress. At the same time, stigma, limited English proficiency, and distrust of law enforcement prevent many from seeking help in moments of crisis. Many hesitate to call 9-1-1, and language barriers continue to limit meaningful access to crisis support.

While we support greater transparency in 9-1-1 data and efforts to strengthen 9-8-8, reforms must include meaningful community representation, expanded multilingual capacity, and equity-centered accountability measures to ensure immigrant communities receive health-based responses. At AAFSC, we provide free mental healthcare in trusted, culturally familiar settings alongside domestic violence services, preventive services, housing navigation, legal support, and food assistance. This holistic model is essential for long-term well-being, yet sustaining it is increasingly difficult as demand rises. We respectfully urge the Council to invest in culturally responsive, community-based organizations, strengthen multilingual capacity across 9-8-8,

develop equity-centered performance metrics, and fund public education campaigns delivered through trusted messengers. Improving transparency is critical, but true equity requires sustained partnership with the communities most affected. Thank you for your time and consideration.

SOFINA TANI: Thank you, Chair Cabán and Members of the Committee for providing us the opportunity to testify. My name is Sofina Tani, Senior Program Coordinator at the Asian American Federation. We are testifying as part of our Asian American Mental Health Roundtable, a coalition that works to address mental healthcare. The roundtable continues to report a sharp rise in mental health challenges among Asian New Yorkers driven by aggressive immigration enforcement policies, persistent anti-Asian hate, and ongoing uncertainty at the federal level. Fear of deportation and surveillance compounded by stigma, limited English proficiency, and distrust of law enforcement directly shapes how individuals seek help. As Council Members noted, the recent case of Jabez Chakraborty illustrates how systemic issues with 9-8-8 and 9-1-1 can fail our communities. His family sought help

through 9-8-8 during a mental health crisis, yet the response ultimately led to a police involvement and escalated into violence. This is not an isolated incident. Experiences like this deeply affect how Asian New Yorkers perceive crisis response system, shaping whether individuals feel safe calling a hotline or interacting with police during a mental health emergency. Establishing a task force and launching a public education campaign are important first steps toward greater transparency and accountability around 9-8-8. However, without a clear commitment to equity, robust language access, and meaningful community collaboration, these reforms will not fully help. The people who need them the most.

We urge the Council to consider the following. Consult Asian-led and immigration-serving community organizations when reviewing 9-1-1 reporting data. These groups are already providing crisis support and can ensure data reflects lived realities, not just system metrics. Include Asian-serving CBOs on the 9-8-8 task force to ensure recommendations reflect the needs of immigrant communities. Directly fund culturally and

linguistically competent CBOs because they're already delivering crisis and emergency mental health support, but lack funding to meet growing demand. Build partnerships with trusted community hotlines for smoother referrals and strengthen language access across 9-8-8, as well as provide culturally competent training and mental health support for staff experienced vicarious trauma. Develop equity-centered performance metrics and publish them annually. And finally, deliver multilingual public education campaigns through ethnic media, faith institutions, and grassroots partners to increase awareness and reduce stigma. Thank you for your continued leadership and for the opportunity to testify today.

JONATHAN CHUNG: Good afternoon, Chair Cabán, Council Member Felder, Members and Staff 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, the only non-profit in the city providing free, direct, and extensive family support and peer services to New Yorkers caring for someone living with mental illness. I also serve on the steering Committee of the Correct Crisis

Intervention Today Coalition. Thank you for holding today's important hearing.

First, I want to affirm NAMI NYC's support for Intro. 722, sponsored by Council Member Schulman, which would increase transparency in the City's B-HEARD program. Requiring regular reporting on mental health emergency responses will allow policymakers and the public to better understand what is working and where improvements are needed. We also support the Pre-Considered Introduction sponsored by Council Members Lee and Cabán, which would establish a task force to study and strengthen the 9-8-8 system and require a public education campaign about 9-8-8 and the available crisis services. The 9-8-8 Suicide and Crisis Lifeline is a critical tool that connects New Yorkers to trained counselors, clinicians, and peers. The City must ensure it is well-resourced and that every New Yorker knows how to access it. NAMI NYC urges this Committee and the full Council to pass these important pieces of legislation. At its core, addressing the mental health crisis really requires decriminalizing mental illness. Too often, individuals in crisis encounter law enforcement instead of care. New York City should commit to

stable funding for 9-8-8 and reform B-HEARD to create a transparent, peer-led, non-police crisis response system available citywide. At the State level, passing Daniel's Law would establish this framework, and the bill should be paired with reforms to strengthen and expand alternatives to incarceration, including greater use of mental health courts and the passage of the Treatment Court Expansion Act, so more individuals can access rehabilitative care. We must build an infrastructure that allows people to receive community-based care. This includes increasing the number of crisis stabilization centers and crisis respite centers, of which we appreciate the Council's leadership on this issue, and expanding the number of Intensive Mobile Treatment, Assertive Community Treatment, and mobile crisis teams so clinicians and peers can reach people where they are. We must create more permanent supportive housing units and lower barriers to entry because stable housing is important to recovery. We must also invest in the behavioral health workforce by increasing salaries for mental health professionals and peer specialists as well as create avenues for diverse providers to enter the field so people living with mental illness can

receive culturally competent care. We need to reform the hospital discharge planning process so individuals leaving psychiatric or emergency settings are connected to housing, treatment, and community supports. For young people, expanding school-based mental health clinics across the school system is critical, especially as youth mental health needs continue to grow and barriers and stigma remain. Taking these steps would represent meaningful progress, but they are only part of what is needed to build a mental healthcare system New Yorkers deserve. We must also strengthen prevention and early intervention systems, support families and caregivers who are the first and last lines of defense, and center the voices of people with lived experience. Thank you, Chair Cabán, for the opportunity to testify today. NAMI NYC appreciates your leadership on this issue, and we stand ready to serve as a resource to you, the Speaker, and the City council. Thank you.

CHAIRPERSON CABÁN: Thank you very much. Thank you everybody for your testimony.

Before calling the next in-person panel, we are going to hear from Ryan Smith, who is the

Director of the Department of Community Safety in Durham, North Carolina, who's present on Zoom.

RYAN SMITH: Good afternoon. Can you hear me?

CHAIRPERSON CABÁN: Yes.

RYAN SMITH: Thank you.

CHAIRPERSON CABÁN: Thank you so much for being with us. We really appreciate it.

RYAN SMITH: Thank you for the invitation. Happy to be here. This is important work.

Good afternoon, Chair Cabán and Members of the Committee. My name is Ryan Smith. I serve as the Director of the City of Durham's Community Safety Department in Durham, North Carolina. Our department represents a new branch of public safety. We operate one of the most robust alternative response programs in the country known as HEART. I'm here to share evidence from our work and lessons we've learned over our first 40,000 crisis responses. In 2021, we started with 13 vacant positions and a mandate to reduce harm, extend care, and increase stability for neighbors experiencing crises. After a year of planning, we launched HEART. Four years later, we are a department of 90 professionals including licensed

clinicians, peer support specialists, and EMTs. We're fully integrated into 9-1-1, we are dispatched as primary first responders to a broad range of calls beyond just mental health. Most often, we are dispatched instead of police, not just after or with police. This model has allowed us to scale from a small pilot to a citywide 15-hour-a-day operation with overwhelming public support and increasing support from law enforcement. Our impact has been independently verified by researchers through rigorous evaluations, and the data is clear. HEART is safe. In over 40,000 responses, we have only had two minor injuries. Our teams report feeling safe over 99 percent of the time, and requests for police backup for emergency safety occur less than 0.5 percent of the time. HEART is cost-effective. HEART generates a net government savings of 900 dollars per response. HEART builds trust. After just one year of operation, 57 percent of residents said HEART's presence made them more likely to call 9-1-1 in a crisis. HEART reduces arrests and citations. Among calls receiving a HEART response, crime reports dropped 58 percent and arrests fell by 56 percent compared to qualified calls handled by police. HEART also importantly

increases voluntary transportation to services and support. Instead of jail and arrest, people are more likely to be connected to care that can address the needs of their underlying crisis. HEART saves police significant time. HEART responds on average in about 12 minutes from dispatch and has also improved response times for police by three minutes. Additionally, HEART has diverted thousands of calls from law enforcement, freeing up officers who are short-staffed to respond to calls where they are most needed. Last year alone, we saved law enforcement over 8,000 hours in response time. HEART is also increasingly viewed as an essential resource and part of our public safety team and available to support better outcomes on the scene. And this is true for law enforcement. When the program launched, just 37 percent of officers felt HEART would be helpful. After just one year, that number increased to 67 percent of patrol officers who viewed HEART as helpful in responding to mental health calls. Almost done. I want to start --

CHAIRPERSON CABÁN: Take your time. All good.

RYAN SMITH: Okay. I want to end with some recommendations for consideration from what we've learned. I know that you all are considering a community safety department. I've had the great privilege and joy of leading one for the last five years. For a community safety department to flourish, I offer four recommendations for your consideration.

First, 9-1-1 integration is absolutely crucial. The program should be integrated within the 9-1-1 system. That doesn't preclude connections to 9-8-8, but if you're not integrated in 9-1-1, you are missing opportunities to reduce harm and extend care. I would also add that our Durham 9-1-1 system operates as a separate department independent from police. That has worked really well for our city, and I'd encourage you to consider this.

Second, I encourage you to extend the scope for such programs beyond calls that are just coded as mental health. In 9-1-1, there are so many other calls that often involve a behavioral health or mental health component, but they get crowded out by other call natures. HEART, our community response teams, which is our primary non-law enforcement response, we send them to calls that we used to send

police to that we no longer send police to, and that includes calls like trespass and all welfare checks, both urgent and non-urgent. These represent a large portion of calls that we are responding to without law enforcement now.

Third, independence is important. I would encourage you, if possible, not to embed community safety in an existing agency. While collaboration with police and other agencies is vital, the greatest benefits come from an independent branch of public safety that manages its own staffing and its own culture. When a program is a sub-office of a larger agency, it often has to compete for resources, for leadership attention, and for 9-1-1 priority. By making it a standalone department, we ensure that community safety is treated as a primary city function and not as an add-on.

Finally, the work should move toward 24/7 in all cities, and it shouldn't be limited to 12 hours a day. In Durham, we're at 15 hours a day. We will eventually be 24/7. We don't limit law enforcement, we don't limit fire to 12 hours a day. We expect it to be available in all hours where,

where those crises are occurring, and in every city those crises are occurring 24 hours a day.

Finally, and this is in response to some of the things I heard earlier, a word on data. So, data reporting and transparency have been absolutely crucial to our success in Durham. We have a public-facing dashboard that provides a wide range of data points on our program. That data is updated at least monthly and often weekly, and I would encourage you all to check out the dashboard to see the kind of data that we are able to report on a regular basis about our program.

In closing, it's a great privilege to be here. We love being part of a community of practice of other cities that are committed to this work, and we're committed to supporting other cities where we can and sharing our data, our policies, our protocols, our trainings. Thank you for the opportunity to testify today. I'm happy to answer any questions.

CHAIRPERSON CABÁN: Thank you. I mean, there's so much wealth of information in the testimony you gave, and I know that you have been meeting with Members of our Committee Staff so, I

really appreciate the partnership. I think one thing that's really interesting is, and this is true across programs across the country, but the police, the law enforcement buy-in. Can you talk a little bit about what that process was like?

RYAN SMITH: Yeah. One, it didn't happen by accident. We were very intentional from the beginning in building police support for this. I think it started with the top. We were fortunate that the city hired a police chief at the same time that I was appointed to be Director of this department, and it gave the city leadership an opportunity to make clear as they were hiring that this was the direction they were going, and they were looking for law enforcement leadership that would be supportive of that. And they knocked that out of the park with our current Police Chief, Patrice Andrews, who has really been supportive. We committed to regular weekly meetings That's where it started. We created a multi-agency planning team in our first year, and I would say two important things about that. So, we wanted to make sure that we had law enforcement and other public safety representatives as well as behavioral health partners at the table, but that

table was not a table where everyone had to agree. That table was not a table where we needed everyone to agree on the call types we were going to go to. And I think had that been the case, it would've made the calls that we go to much smaller. But the thing that that table did for us is it was a chance for weekly for us to learn together. So, we talked to other cities who were doing this work. We looked at their data. We tried to understand the concerns. Law enforcement's chief concern was, frankly, you're going to get someone killed and this is just one more person that I have to show up and, like, rescue on scene. Through those conversations, we got to demonstrate that we were taking that seriously, that we understood the unpredictability and the risk inherent in 9-1-1 calls, no matter how well they're triaged. And we were able to communicate, while not satisfying all of their concerns, the steps that we were taking to take that seriously. At the end of the day, the thing that got police on board with us the most was we operate on the same radio channel as law enforcement. And I've had so many officers come up to me and say, I was skeptical, and they might use other words, I was very skeptical about this, but I hear

you all taking calls every day that I'm not going to, you're not pressing the emergency activation button, you are resolving those calls.

CHAIRPERSON CABÁN: Yeah.

RYAN SMITH: I think that being able to hear us work every day and see that we're answering these calls and saving time. And then, you know, on the occasions where we interact together or work as teams, that has really built a lot of support and it's been reinforced by leadership, and it's taken time. But I think the doing of the work, the transparency around that work and doing it well goes a long way, and I think we have built a lot of support. We have more officers today requesting us. Each year we have seen an increase of that, and officers who meet with our Chief are increasingly asking, when are we going to get more HEART units because we aren't able to get to all eligible calls yet, and we're moving in that direction.

CHAIRPERSON CABÁN: Thank you. Yeah. A couple of things there. I think brilliant that obviously officers are getting to hear these calls being handled. And to your point, I think just an example I'd love to just share with you and for the

record is when I went to visit Denver Star, they told me the story. I love retelling this story. They told me a story about responding to a call where, you know, a caller called in about an individual who was in an acute mental health crisis and had a bunch of rocks in their pocket and a rock in their hand. And when this call came in, I mean, from a police perspective, they're like, that's a weapon, you guys can't go answer this call, that's us. And, you know, their alternate responder, the STAR team, was like, no, no, no, we got this, it's okay, we're fine. And they went in, they called on scene. To your point, they're always a second away from police backup, although they almost never use it, and they engaged this person. The person at some point was like sitting on a curb with those rocks in their hand, in their pockets and the first responder, the alternate responder, went and sat down next to them and talked to them. And as the conversation was continuing, one by one, a rock came out of their pocket, another rock came out of their pocket, another rocket, until they were all just like on the floor and not in the person's possession. And when they debriefed the call afterwards, the officer that was available, right,

nearby, said, we would have never allowed that to happen. You mean you sat side by side next to this person who had rocks with them? And they said, yeah, I didn't assess that situation the same way you are trained to assess a similar situation. And because of that, we were able to get the outcome that we did. And so, there's just like a fundamental difference in how we see and experience an environment and a person and assess that threat. And understandably, a police officer is going to assess that threat differently based on their training as a mental health responder would. And so, like, I think those kinds of stories are emblematic of how important this work is. But the other thing that, that really stood out to me was that you the several thousands of hours of calls that they didn't have to respond to. I don't know about y'all, but in New York City, we have an overtime crisis. We are spending --

RYAN SMITH: Yeah. We do too. That's right.

CHAIRPERSON CABÁN: -- millions and millions of dollars on overtime when there are gaps in our continuum of care. So I think, you know, that goes a long way too. So, we'd love to keep talking to

you. We'd love to continue staying in touch and just thank you for your testimony and the information you offered.

RYAN SMITH: Thank you. We're available to support in any way we can.

CHAIRPERSON CABÁN: Cool.

RYAN SMITH: Appreciate the work y'all are doing.

CHAIRPERSON CABÁN: All right. Thank you.

Okay. Now, we're going to go back to in-person panels. Ronald Jones, Ruth O'Sullivan, Laura Savino -- not Ronald? Okay. Carly Shapiro and Paula Magnes.

Council Member, would you Chair the Committee for like two minutes while I go to the restroom?

Yes. You're shaking your head. You're nodding. You're not shaking your head.

COUNCIL MEMBER FELDER: (INAUDIBLE)

CHAIRPERSON CABÁN: That's all right. I already took a break.

You know what? Never mind. She's in charge.

COMMITTEE COUNSEL: So just to confirm, we have Ruth O'Sullivan here. Yep. We have Laura Savino. There you are. Okay. All right.

I think we can call one more. Christina Spark, if you're in the room. You can come up.

RUTH O'SULLIVAN: Good afternoon, esteemed Members of the Committee. My name is Ruth O'Sullivan, and I currently serve as a Senior Director of Clinical Practice for the Center for Justice Innovation. Thank you for the opportunity to testify.

For over 30 years, the Center has partnered with community members, service providers, and government agencies to develop practical responses that address the underlying causes of justice system involvement and strengthen community well-being. Too often, untreated mental health needs become visible only in moments of crisis when individuals encounter emergency services, hospitals, or the justice system. These systems are not equipped to address complex health needs or to support long-term recovery and stability. Effective public safety strategies therefore depend not only on crisis response, but on strong pathways that connect individuals to ongoing care. Significant challenges

exist due to stigma, fragmented systems, and limited continuity of care. Without sustained engagement and support in accessing appropriate treatment, people may continue to cycle through crisis systems. The Center's programs are designed to bridge some of these gaps by connecting individuals to services, strengthening community-based responses, and supporting pathways away from crisis and towards stability. Some examples of our work are the Brooklyn Mental Health Court based in Brooklyn Supreme Court, was New York City's first mental health court, and has served as a local and national model for over 20 years. In addressing both participants' treatment needs and community public safety concerns, the court links participants 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. The goal of the court is to connect people with services that will long outlast the duration of the mandate. Through 2025, over 1,500 participants have received treatment, satisfied program requirements, and graduated, all while avoiding the harms of incarceration. The Manhattan Misdemeanor Mental Health Court helps

people with mental health issues and co-occurring disorders engage in social services that reduce their involvement in the justice system. Participants receive comprehensive support, including connections to mental health and substance use treatment, benefits, housing assistance, and community-based services. Since launching in 2022, MMHC has graduated 616 people. The Midtown Community Justice Center's Community First program serves community members experiencing various levels of housing instability in, in the Times Square area. Often those who need support live under the radar until moments of crisis like an arrest or an emergency room enforces a response. Community First seeks to connect some of the city's most disenfranchised residents through mobile case management, street outreach, and assistance for court-involved and diversion participants. The primary focus is in building trust and allowing participants to identify their own goals. (TIMER CHIME) Bronx Heroin Overdose Prevention and Education Program is an initiative of Bronx Community Solutions that gives 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 their underlying issues. Thank you for your leadership and the opportunity to testify today.

PAULA MAGNES: Good afternoon, Chairperson Cabán and the Committee here. My name is Paula Magnes. I'm the President of Northside Center for Child Development. It has served children and families in Harlem for over 80 years. We operate a main behavioral mental health clinic in Harlem and school-based clinics in 23 schools across Manhattan and the South Bronx. We're also the sole designated COMPS provider, which is Community Outreach Mental Health Provider Support for both Manhattan and the Bronx. No other agency in New York City serves in those boroughs under this capacity.

We strongly support both bills before the Committee today, and I want to offer what I believe is uniquely useful testimony on each. Our full written statement, which has been submitted, and we'll put it online as well, I encourage the Committee to review it for the details behind what I'm about to say. On T2023-3879, our community

wellness specialists are in Harlem and the Bronx every weekday. In direct conversations with the residents, what they find consistently is that most residents have never heard of 9-8-8. Among those who have, the dominant misconception is that 9-8-8 is only for suicidal crisis. Residents do not know it is available for emotional support, for referral, or for anyone who simply needs someone to talk to. They are not calling because they do not believe 9-8-8 is for them. That is exactly the gap a well-designed public education campaign built around trusted community messengers like our COMPS program can close.

On Initiative 0722-2026, we can offer the Committee a concrete data point. Northside has never received a referral from a B-HEARD team despite operating in the same Harlem and South Bronx neighborhood B-HEARD serves. Our community wellness specialists were not even familiar themselves with it prior to preparing this testimony. The City's COMPS program coordinator has provided no training or guidance on B-HEARD coordination. This is not a criticism or individual, you know, responders. It is evident of a structural gap. Crisis response and community-based care are operating in the same

neighborhood with no connection between them. That coordination needs to happen. Quarterly reporting is a necessary first step. We urge the Committee to pair it with a requirement that relevant City offices develop formal referral protocol connecting B-HEARD responses to community-based providers (TIMER CHIME) starting with the COMPS network that already exists for the exact same purpose. Thank you for this time and the opportunity to present.

CHAIRPERSON CABÁN: Thank you. And we're going to follow up with the folks from B-HEARD on that disconnect because that's certainly concerning. I know that apparently B-HEARD, my District is in their catch precinct. I will say I hate the fact that they do it by precinct rather than different geographic areas, like if we're going to really separate this from a policing apparatus. That doesn't quite make sense to me. But yeah, like, you know, my precinct didn't know what B-HEARD was despite it being, you know, in my District so, yeah, that's something that we'll follow up on. Thank you.

CARLY SHAPIRO: Good afternoon. My name is Carly Shapiro, and I'm a Forensic Social Worker at New York County Defender Services. NYCDS is an

indigent office that each 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 today's bill. In addition to a master's in social work, I also possess a master's in public health.

The Social Work Unit at our office encounters barriers at nearly every stage of connecting clients to mental health and related services. I focus today on two specific areas: single point of access services, also known as SPOA, and emergency and transitional housing, not because they are the only problems, but because they are areas where we can identify concrete solutions. And where a clear fix exists, there is no justification for delay.

SPOA is the primary gateway to high-intensity community-based mental health services. Services include a basic wellness coordination tier, intensive 24/7 support, and mobile units supporting those with the most acute mental health needs and housing instability. I know that someone previously said they review applications in

two days, but we have found that our clients can wait six months, if not two years, to be connected to these services. MOCJ Emergency Transitional Housing Program offers stays of 6 to 12 months across all five boroughs. And although these programs fill a critical gap, the process to secure a bed is unnecessarily complicated and fragmented. There is no centralized intake, no publicly bed-available data, and no shared referral system. This means every social worker, everyone in our office needs to contact individual providers, all of whom have different application processes, and we might not even get a response. An NYCDS client was recently held on Rikers for over a year waiting for either housing and a SPOA assessment or his Manhattan Drug Treatment Court assessment. After 12 months, he was finally assessed for treatment court, but no connection to services or housing. The judge agreed to have him live in a shelter for the time being, and 16 months later, he's still waiting for SPOA and housing. As a result of these delays and gaps in care, he has significantly decompensated, and this was preventable. There are countless more examples when NYCDS has had a judge agree to release if and

when there are SPOA services and housing in place, but given the wait times, individuals just sit on Rikers Island. Time does not stand still in jail. It compounds harm, erodes stability, and deepens trauma in ways that cannot be undone. The answer is simple. What is lacking is funding and a political will for real investment in the people and communities in great needs of timely access to quality and care. Thank you for holding this important hearing, and we look forward to working with your office.

CHAIRPERSON CABÁN: Thank you. I think something that you didn't mention that I think is also true is that when you have a client who gets released because they have, you know, they've been accepted, but they're on a waitlist, if they have an open case and they don't get the care that they need, they are at high risk of being re-arrested and having another open case, which could make it so that they're no longer eligible for any non-incarceratory sentence in their original case. But understanding, like, the underlying problem is actually a barrier to access to care so it's compounding.

CARLY SHAPIRO: Yeah. From my understanding, the client hasn't picked up another case, but I do know he has been in and out of --

CHAIRPERSON CABÁN: Yeah.

CARLY SHAPIRO: -- inpatient hospitals.

CHAIRPERSON CABÁN: But it's easy. It's easy to pick up another case when you don't have stable care.

CARLY SHAPIRO: Yes.

CHAIRPERSON CABÁN: Yeah. Thank you.

LAURA SAVINO: Good afternoon, Chair Cabán, Committee Members. My name is Laura Savino. I'm a licensed clinical social worker and also the Senior Vice President for Care Management at Institute for Community Living, which is also known as ICL. ICL serves more than 10,000 New Yorkers annually and houses 4,000 people each night across the five boroughs. Behind those numbers are people, parents, survivors, veterans, all of who rely on us not just for services but for stability. ICL has seven ACT teams and six IMT teams. And as we know, IMT is a multidisciplinary community-based team that provide long-term care to New Yorkers with severe mental illness and substance use challenges, many

with deep involvement in the justice and the shelter systems. IMT works because it's sustained, mobile, and rooted in the community. It helps people stabilize, remain housed, and avoid costly and traumatic system cycling. Yet today, as we've heard, nearly 700 New Yorkers sit on both ACT and IMT waitlists. These are individuals continuing to cycle through the shelters, emergency rooms, and incarceration, all while we know that there is a model that works. The problem is not effectiveness, the problem is capacity. Without funded step-down services, clients who have stabilized in IMT and ACT remain in high-intensity slots longer than clinically necessary because there is no structured bridge to lower levels of care. What that does is it bottlenecks and prevents us from reaching people in acute crisis, and it keeps the door closed for those who need it most. This is why in 2023, ICL launched STEPS, Step Down Treatment to Ensure Personal Success, which is a recovery-oriented pilot designed to provide structured transitional support at a lower intensity to free up critical IMT capacity. So, in year two, STEPS served a little over 73 clients, and here are some quick statistics. Of those 73 clients,

97 stayed within their housing community. 89 percent avoided hospitalizations, 86 percent avoided ER visits, and 100 percent were not arrested or incarcerated. STEPS also reduced IMT and ACT waitlists by 5 percent, which expanded access without expanding crisis. STEPS is also cost-effective. It's a fraction of the cost of IMT, which expands the system capacity. The Council recognized this and allotted 11 million for IMT step-down services and 4.5 million (TIMER CHIME) specifically for STEPS in the FY26 budget. Yet, the 4.5 million has not been procured. We cannot allow a proven life-changing intervention and continuity of care for these vulnerable New Yorkers to stall. If we do, they risk disruption, displacement, and a return to their instability, and we are urging immediate procurement of these allotted funds and full investment to scale down STEPS services citywide. If we want a system crisis that works, we must fund one that works. Thank you for your time and your partnership.

CHAIRPERSON CABÁN: Thank you.

CHRISTINA SPARROCK: Can you hear me? Good afternoon, Chair and Member (INAUDIBLE) excuse me. Okay.

CHAIRPERSON CABÁN: You're good.

CHRISTINA SPARROCK: Can I set the time? Okay, good. Good afternoon, Chair Cabán, Members of the Committee on Mental Health and Substance Use. First of all, thank you Member Cabán, for disclosing your mental health condition. That's really courageous in a society where people are shunned, steamed as dangerous, and less than human. You give me hope and other people hope that we could be seen as people. Thank you for normalizing mental health in working to end the stigma. So, thank you so much.

My name is Christina Sparrock, and I'm an Alternative Crisis Response Researcher at the Disability Justice Program at New York Lawyers of the Public Interest. I'm working to identify alternative crisis response all over the country, including HEART, which we learned earlier. I'm also on the Daniel's Law Task Force and on the Behavioral Health Technical Assistance Substance Crisis TACT team on OMH, these long titles, but I'm here to represent NYLPI. I'm someone with lived experience with mental health challenges, and the stigma is real and influences how systems respond to people like me during a crisis. During one crisis, I had a wellness

check. Well, I didn't even have a crisis. It was a wellness check. Police pounded, came to my door unannounced, to my apartment door, and I didn't even know who they were. I believed it was a violent intruder that was trying to enter and harm and kill me. In fear, I looked to protect myself, and what I did is grabbed a knife because in my home, as a single woman, I was going to protect myself, do or die. The pounding had stopped, and I called the doorman, and the doorman had said it was the police doing a wellness check. If my door was unlocked, I would have ended up like another Eleanor Bumpurs, Win Rozario, Zepedana (phonetic), Eudes Pierre, and the list goes on. And this is why precisely we don't need police to respond to mental health crisis or even like wellness checks or even other situations, and we need peers included. It is imperative that we remove police from mental health crisis response until requested by a first responder who must be a healthcare or peer with lived experience. While the City is currently running a non-police response known as B-HEARD, which operates in 31 precincts, the program is fraught with problems, including having too many calls that go to the police, having NYPD

screen all the calls, not placing peers on the team, and not having 24 hours for it to be operational, and not having community input, because we know that the Fire Department, City, and Health and Hospitals actually were the ones who decided the program. In the future, it's absolutely critical that we incorporate peers in B-HEARD, or whatever response the City decides to develop, as many programs across the country have done successfully, which you heard of HEART. During a crisis, we deserve dignity, de-escalation, and not force. Transparency and accountability are essential in the crisis response model. New York City former Comptroller Brad Lander's audit report identified serious gaps in the Office of Mental Health (TIMER CHIME)

CHAIRPERSON CABÁN: Go ahead.

CHRISTINA SPARROCK: Thank you. Ability to track B-HEARD data, including the response time, how often individuals are served, whether follow-ups occur, and other key indicators necessary to ensure New Yorkers are safe and properly cared for. Without data and reporting, we cannot evaluate effectiveness. New York City is facing a 16-billion-dollar budget right now, and the Mayor and the City are negotiating

tough budget decisions as New Yorkers deal with unaffordable housing, rising health premiums, Medicaid cuts, unlivable wages, increasing violence, and now a war. This will lead to more mental health crisis. At the same time, we expected to rely on crisis response systems that often limit publicly available resources of effectiveness, as well as police response. As taxpayers, we expect that our dollars will fund effective programs like B-HEARD or whatever program you're going to decide to choose on but it must be seen over the Office of Community Mental Health or the Department of Community Safety or whichever agency. Data collection and public reporting as required by Intro. 722 would allow us to measure outcomes and find gaps and enhance services. Finally, as New York State moves from using pejorative language like EDP, emotionally disturbed people, which all of us know, to person experiencing an emotional crisis, which is PEC, which was passed by legislation last year, which I helped on. I'm glad. All aspects of crisis response and mental health service deliveries, including data systems, must reflect that change. Language matters. It

reflects our values and our commitment to dignity. Thank you.

CHAIRPERSON CABÁN: Thank you so much. Thank you for your kind words. Thank you for sharing your own personal experiences. And thank you all for your testimony.

All right. Okay. This is our last in-person panel before we move to a few Zoom panelists. We have Hector Garcia, Tom Harris, and Frances Geteles.

FRANCES GETELES: Oh, I'm first.

CHAIRPERSON CABÁN: Yeah. You're up.

FRANCES GETELES: Okay. Thank you very much for letting me testify. My name is Frances Geteles, and I'm a clinical psychologist, and I'm also a member of several advocacy organizations that are working on the jail system here. so that's the Halt Solitary Campaign, the Jails Action Coalition, and Mental Health Alternatives to Solitary Confinement. The current numbers of people who are incarcerated right now, there are approximately at Rikers somewhere between 7,000 and 8,000 people, and that's a very high number. And of those, 59 percent are people who are registered in mental health

programs. That is not the necessarily the most serious, but among them, for example, 22 percent are people who do have serious mental illness, 30 percent are people with alcohol use disorder, and another 20 percent with opioid use disorder. So, what we have is what looks like, in fact, it has been referred to as one of the biggest mental health hospitals in the country. I think either first or second.

CHAIRPERSON CABÁN: It's the biggest in New York State.

FRANCES GETELES: Pardon?

CHAIRPERSON CABÁN: It's the biggest in New York State.

FRANCES GETELES: Yes. But I also think in the country. So, the big question is, how did we get there? We used to have mental health hospitals. But throughout the period from the 1950s to the 1980s, there were these huge reports of talking about how bad those places were, that they were much more like dungeons than care facilities, that they were dehumanizing to the people and just generally destructive and hurtful. So, finally in the '80s, after all these reports on how terrible these places were, the decision was made to dehospitalize. That's

what the advocates were asking for, and that was what happened. However, there was another part to the offer of, or the legislation about dehospitalizing, and that was the plan to set up (TIMER CHIME) community-based care centers, and that was really not done adequately. In fact, they, they never really kept word. There are a few throughout New York State since that's what I'm talking about, but nothing to be in touch with the degree of need that we have for people with mental health problems. The groups I'm working with now are fighting, in fact, to try to limit the number of people who are sent to prisons, specifically focusing on the mentally ill and the physically ill and people with cognitive disorders, none of whom belong there in the prison and yet it's going to be a big deal to try to get them out. Because it's what we're really asking for is a kind of very heavy investment of funds. And I think so many of the people that spoke here today were also talking about the need for funds. Now, of course, on the other side, if we're optimistic about how effective that could be, it could certainly reduce what we're paying to run the jail system. We don't need such a big jail system. What we need are ways to

really care for and look after our people. And so that's, I think, what we're fighting for. I wanted to think of also some of the things that I would like this Committee to focus on.

CHAIRPERSON CABÁN: I'll just ask for you to wrap up and then make sure if there's anything else you don't get to, you can submit written.

FRANCES GETELES: Yeah. I haven't gotten through writing it, but I will.

CHAIRPERSON CABÁN: Okay. Well, you got 72 hours.

FRANCES GETELES: Two hours?

CHAIRPERSON CABÁN: 72. 72, not two.

FRANCES GETELES: That's what I thought I had.

CHAIRPERSON CABÁN: Yeah. No, no, no,

FRANCES GETELES: Because I have all day tomorrow.

CHAIRPERSON CABÁN: Okay.

FRANCES GETELES: Hopefully, that'll work.

CHAIRPERSON CABÁN: Yeah. But I guess what we really would like to see happen is that old promise is kept true in a sense, that we get as many people as possible who have all these medical and

mental health problems, and I would like to see even more people than that taken out of the jail. But I just wanted to say one thing. When these people are in our jail system, the jail system is very brutal and very abusive, and the people that are particularly affected by that would be the people with mental health problems because they're going to have the most difficulty --

CHAIRPERSON CABÁN: Sure.

FRANCES GETELES: -- in keeping in touch with the rules and obeying the rules, and so what ends up is they are more than anyone else placed in solitary confinement. They are more than anyone else the ones who are brutalized. They often don't get the medications they're supposed to have. So, all of that is going to traumatize them even more than they already are with the psychological problems and the events in their lives that have led them to have these mental health problems.

CHAIRPERSON CABÁN: Thank you.

FRANCES GETELES: So, the focus is they have to be brought out of there and into community-based, genuinely caring treatment centers.

CHAIRPERSON CABÁN: Thank you.

FRANCES GETELES: And that's what I hope that you can somehow help us to make that happen.

CHAIRPERSON CABÁN: Thank you so much for your testimony.

FRANCES GETELES: Okay.

CHAIRPERSON CABÁN: I think we have wrap and we're going to move to the next person to testify. And again, if there's anything else you want to add, you've got 72 hours to put that in your written. Thank you so much.

FRANCES GETELES: Thank you.

HECTOR GARCIA: Good afternoon, Chair and Members of the Committee. My name is Hector Garcia, and I'm the Director of Lantern House Clubhouse in the Bronx, a program of Goodwill Industries of Greater New York and Northern New Jersey. Goodwill operates behavioral health programs across New York City, including two accredited clubhouses and two PROS programs, which support individuals living with serious mental illness. These programs provide community structure and rehabilitation services while also helping members build skills and reconnect with employment and community life. Our clubhouse model is built on the idea that recovery happens in community.

Members participate in the daily operation of the program, develop social and vocational skills, and receive support as they pursue education and employment. Being embedded within a workforce organization like Goodwill also allows us to connect members to job training and employment opportunities, creating a pathway from recovery to economic stability. The need for these services is extremely high. Every day we meet New Yorkers who are looking for a place where they can develop coping skills, build confidence, and move forward with their lives. However, one of the biggest challenges we face is not a lack of need, but rather it is a lack of consistent referrals. Programs like ours have the capacity to serve more people, yet too often individuals who could benefit from Clubhouse or PROS programs are never connected to us. The City's centralized referral effort through MAVEN was intended to help solve this challenge. In theory, a coordinated system that helps transition individuals from clinical providers into community-based (TIMER CHIME) rehabilitation programs is exactly what the system needs. In practice, however, these referral pathways are still inconsistent and fragmented. Too often,

people leaving hospitals or other mental health providers are not effectively connected to programs like ours. As a result, individuals who would benefit from ongoing community-based support may fall through the cracks. Clubhouses and PROS programs are designed to be a landing place, a place where people can continue their recovery while building the skills and stability needed to return to work and community life. Strengthening referral coordination and ensuring systems like MAVEN function as intended would help ensure more New Yorkers are connected to these services at the moment they need the most. Thank you for the opportunity to testify and to your commitment to improving mental health services for New Yorkers. And additionally, thank you to Chantal Bodeiro (phonetic) our Clubhouse member, for attending with me today.

CHAIRPERSON CABÁN: Thank you.

TOM HARRIS: Thank you very much, Chair Cabán and Council Member Felder. My name is Tom Harris. I'm the President of the Times Square Alliance. As public space managers, we care deeply for not only the neighborhood, but for the people who live in it. We partnered with the Center for Justice

Innovation to implement Community First, which another speaker spoke about, to reduce street homelessness by 67 percent. We partner with Fountain House to have a recharge station in the middle of Times Square to connect people with mental illnesses with services. We are the boots on the ground that see the struggles that those living on the streets with mental illness challenges face, and we see the challenges in them getting service. We see the failures of this system, and we're here today because we need to do better to help our most vulnerable. The core problem is a lack of shared vision, meaningful measures of success, coordination, communication, and accountability.

I want to tell you one story. Jane lived on 41st Street and 8th Avenue for seven years while there was a private room available for her four blocks away in Times Square. She insisted she had a lease for her street corner at 41st and 8th Avenue. Up to nine separate outreach teams, including peer navigators, offered Jane duplicative services daily without coordination. Every day she declined, suffering from psychosis, delusions, and deteriorating self-care. We watched nine agencies

wait for her to get sicker before they would help her. Ultimately, through persistence, Jane is in a supportive setting and doing well. Jane is not the exception to those living on the street with a mental illness. She is the norm. We have advocated for countless clients like Jane. In the past 16 years, spending on street outreach has increased 1,000 percent and homelessness has increased 22 percent. Most have mental illnesses. Outreach is not the answer. Focusing on outcomes is. The system is resource-rich and accountability-poor. To meaningfully address street homelessness and support clients facing serious mental illness, we need to change the mindset that people have a right to die slowly on our street. I want to be clear, this is not about involuntary removal, which happens infrequently and is only a last resort. This is about reducing or eliminating police involvement. This is about a unified shared goal of permanent supportive housing tailored to the needs of the individual. This is about sharing information. This is about coordinating care amongst the City street outreach, health healthcare and housing systems. They need to work together, not in silos. This is about holding

providers accountable for outcomes, not outreach. This is about focusing on connecting the dots and having all the information available so the next Jane doesn't need to wait seven years for help. Thank you.

CHAIRPERSON CABÁN: Thank you. I didn't have my mic on. Whoops. I'm good.

Okay. Now we are going to move to Zoom testimony. Please wait for your name to be called to testify and select unmute when prompted.

Okay. So, I'm going to give the full list and then I will call who's going to start. We have Zev Vel, Sakeena Trice, Jihoon Kim, Nicole Robinson-Etienne, Peggy Herrera (phonetic), and Christopher Leon Johnson.

And we'll start with Zev.

SERGEANT-AT-ARMS: You may begin.

ZEV VEL: Good afternoon. My name is Zev Vel, and I am the Program Director of Goddard Riverside's Intensive Mobile Treatment Program. I want to begin by thanking Chair Cabán and the Members of the City Council for holding this important hearing and for your continued commitment to New Yorkers with the highest needs. Goddard Riverside is a multi-service social services agency serving over

22,000 New Yorkers annually through a variety of programs, including our ACT and IMT teams. Goddard's IMT team launched two years ago and supports 27 clients at full capacity across all boroughs. We stay with each individual until they are ready for a lower level of service and meet our clients where they live, spend time, or feel most comfortable in the community so that we can build trust, collaborate, and support them in addressing their mental health needs.

I want to share a story of a success of IMT. A client, I'll call Jay, joined us in late 2024. At the time, he was living in a shelter. He was disconnected from psychiatric care, responding to hallucinations, hospitalized repeatedly, and becoming involved in physical altercations. Jay is deaf and lip reads, and we quickly learned that most of his conflicts stemmed from not being understood. In fact, he wanted treatment and support. Today, Jay is thriving. He lives in supportive housing, receives a monthly injectable medication, attends Goddard's top clubhouse almost every day, and is actively applying for jobs. With continued support, he is moving towards discharge.

There are many New Yorkers like Jay, people who can succeed in the community with a period of intensive sustained support. But IMT waitlists remain exceedingly long, as we've heard earlier in this in this session today. We respectfully urge the Administration and Council to expand the intensive services like Intensive Mobile Treatment in the upcoming budget so we can reach the many individuals still waiting for this vital care. Even with IMT support, many clients still face major administrative barriers, including a lack of photo ID and other vital records. There's a lot of difficulty in meeting these requirements to obtain them as well. These obstacles delay housing, benefits, and overall stability. We urge the Council and the Administration to partner with providers to reduce these barriers for individuals engaged in IMT, ACT, and similar programs. Exploring legislative and regulatory changes that streamline access to photo identification and essential documents would be a powerful and immediate step towards ensuring that New Yorkers who need support the most are not held back by paperwork. Thank you for your time, your leadership, and your commitment to this work. We're

available to discuss these ideas further as we collaborate on making a more equitable city.

CHAIRPERSON CABÁN: Thank you.

Next, we'll have Sakeena Trice.

SERGEANT-AT-ARMS: You may begin.

SAKEENA TRICE: Good afternoon, Chair and Members of the Committee. My name is Sakeena Trice, and I am a Staff Attorney with the Disability Justice Program at the New York Lawyers for the Public Interest. Thank you for the opportunity to testify.

Our current mental health crisis response system is simply not working, and this is what Black and Brown communities, people with disabilities, families in crisis, civil rights attorneys, and other advocates have been saying for years. It is too limited, too under-resourced, and too intertwined with policing to deliver real transformation, and lives are being lost. Despite the City's claims, B-HEARD is not a true non-police model. Most mental health calls are still routed through 9-1-1 and to the NYPD. During the 2025 audit period, more than 13,000 calls eligible for a health-based response did not receive one. That means thousands of New Yorkers in crisis instead encounter a police response. This

is a flawed system. At the same time, response times for mental health crisis calls have more than doubled in recent years according to the New York City Independent Budget Office earlier this year. When someone is in crisis, minutes matter. Delays escalate situations. Escalation costs lives, disproportionately Black and Brown lives. So, we must change the front doors to the system. As long as mental health crisis calls primarily go through 9-1-1, we are reinforcing a law enforcement framework. 9-1-1 was built for crime response, whereas something like 9-8-8 was created for mental health crisis. If police remain embedded at the point of dispatch and response, we are not transforming the system, we are maintaining it. We call for a fully independent, 24/7, citywide, non-police mental health crisis response where calls are routed through 9-8-8, rooted in trauma-informed care, and led by peers, which are individuals with lived mental health experience. We ask for investments in voluntary, accessible, community-based mental health services that help prevent crises before they happen. And look, these solutions are not one size fits all, but research shows that forced commitment and involuntary

treatment is no more effective than voluntary services and treatment. So, let's try the voluntary way. Incremental reform is not enough. The time to move crisis response out of law enforcement and into public health is now. Thank you.

CHAIRPERSON CABÁN: Thank you.

Next, we'll have Jihoon Kim.

SERGEANT-AT-ARMS: You may begin.

JIHOON KIM: Chair Cabán and Members of the Committee, thank you for the opportunity to testify today. My name is Jihoon Kim, President and CEO of InUnity Alliance. I am also a social worker and peer professional by training and a person in long-term recovery for co-occurring mental health and substance use conditions. InUnity Alliance is a statewide community of 150 substance use disorder and mental health organizations with an extensive network of programs operating across every borough of New York City. Beyond advocacy, we provide training and serve as the exclusive certifying body for peer recovery credentialing in New York State. Our members formed this association to strengthen coordinated person-centered care for people living with substance use and mental health conditions while preserving the

specialized expertise each service system provides. Substance use disorders and mental health conditions remain leading contributors to disability and preventable death. They're also closely tied to housing instability, child welfare involvement, and legal system contact. Like other chronic illnesses, substance use disorders and many mental illnesses are preventable and recovery is expected when care is delivered early. Yet, prevention receives far too little attention, and many New Yorkers face months-long waits for care until manageable conditions become crises that are far more costly and difficult for families to navigate. These impacts ripple through communities and fall disproportionately across New York City. In 2021, psychiatric hospitalization rates were highest in the Bronx at 723 per 100,000 residents, followed second by 529 per 100,000 in Manhattan, reflecting large gaps in timely prevention and care. Overdose death rates among Black and Latino New Yorkers are about twice those of white residents. Workforce shortages, unstable funding, and onerous administrative burdens limit the ability to recruit and retain staff and ensure people receive timely care after crises. To

move from crisis to recovery, targeted investments are needed, to implement the 11-million-dollar IMT expansion and the 4.5 million step-down program, to increase the Peer Specialist Supports program to 6 million dollars, and to adequately fund New York City 9-8-8. These steps are especially urgent as federal policy changes threaten to add further strain, including more frequent Medicaid recertification and work requirements that may not account for people who shift in and out of disability exemption status. We appreciate the Committee's leadership on this issue and welcome continued partnership to strengthen the transition from crisis to care. Thank you.

CHAIRPERSON CABÁN: Thank you.

Next, we'll hear from Nicole.

SERGEANT-AT-ARMS: You may begin.

NICOLE ROBINSON-ETIENNE: Hello. Good afternoon, Chair and Members of the City Council. My name is Nicole Robinson-Etienne. I'm the Senior Director of External Affairs at LinkNYC, and thank you for the opportunity to testify.

As you know, LinkNYC began as a replacement for the public payphone, but over the last decade, it's evolved into critical citywide

public communications and connectivity infrastructure. Today, with a network of more than 2,200 kiosks and smart poles, we provide free Wi-Fi, device charging, nationwide phone calling, and direct connections to emergency and social service resources, including 9-1-1, 3-1-1, and a one-touch access to 9-8-8, in addition to housing and cash assistance programs, food pantries, shelters, and much more. The addition of 9-8-8 was not symbolic, it was intentional. We recognize that mental health crises require accessible, immediate, and non-punitive pathways to care, and by placing 9-8-8 in visible everyday spaces, we help to reduce stigma and lower barriers to support. For someone without a smartphone, without data, or without privacy at home, that public access point can be critical. In 2025 alone, more than 6,300 calls to 9-8-8 have been made directly from LinkNYC kiosks, demonstrating that when access is visible and immediate, New Yorkers use it. Since integrating 9-8-8, we have also used our digital screens to build awareness. During Mental Health Awareness Month each May, we launch citywide campaigns highlighting 9-8-8. And in the winter, we ran messaging focused on seasonal depression. We have

partnered with State officials and collaborated with NAMI to ensure trusted community-based mental health resources are visible across our network. We stand ready to support awareness efforts led by City officials and the New York City Department of Health and Mental Hygiene, and to utilize our screens the same way we have for major public information campaigns like 3K and pre-K enrollment and Code Blue weather alerts, delivering timely citywide messaging directly to neighborhoods at street level. Investing in sustained public education will strengthen coordination, expand awareness, and ensure that 9-8-8 continues to serve as a trusted lifeline for New Yorkers. Thank you for your leadership, and I welcome any questions.

CHAIRPERSON CABÁN: Thank you.

Next, we'll hear from Christopher Leon Johnson.

SERGEANT-AT-ARMS: You may begin.

CHRISTOPHER LEON JOHNSON: Yeah. Hello. My name is Christopher Leon Johnson. I support both bills on the thing. but I will make this clear about when it comes to 9-8-8, that this need to be more promoted within the City Council. I don't really see

anything on the City Council website even promoting 9-8-8, which is kind of sad. We get more support from Albany than the City Council when it comes to stuff. Let me make this clear that, sorry, I eat my food, sorry, make this clear that going forward I think the City Council need to make it where that they need to push more campaigns when it comes to stopping the stigmatization of mental illness because there's people, they're not comfortable with disclosing that they see a therapist or they just disclose that they have mental illnesses because it really can be detrimental to their future, you know what I'm saying? You disclose that you have mental illness. So, look going forward, I said going forward, I think in the budget cycle the City Council needs to start investing more money into promoting 9-8-8 and making it where that people should start calling 9-8-8 more instead of calling 9-1-1 because anytime you have a problem, especially personal health crisis, people call 9-1-1, and everybody know what happens after that. The cops come. and look what happened to Win Rozario and the last kid who got shot in Queens, and he got indicted by DA Katz. I know that, Cabán, if you was DA, you wouldn't charged the guy. You

probably got the guy the help he deserved to get. So, look, so like I said money need to start going forward to promoting 9-8-8 and educating people to call 9-8-8 instead of just, you know, just going back and forth with these hearings? So well, that's all I have to say so far. I know in the next few weeks you have the initial health hearing for the budget, and people are also asking the NYPD and many of these agencies, like, why are you not promoting 9-8-8 more? Why y'all want to promote 9-1-1? I mean, that would be my question, but I never know why, they just had to justify lining their pockets up with the budget. I mean they want to inflate their budgets, especially with overtime getting cut with the NYPD under Jessica Tisch, the soccer mom. But you know, I wish you was Commissioner, Cabán. I mean, you should have been Commissioner. I don't know why Mamdani didn't appoint you as Commissioner, you know what I mean? I think if you was Commissioner, you probably did a way better job than Tisch is doing right now, especially with stopping the criminalization of deliveristas and cyclists, which creates a lot of mental health things, you know what I mean? Getting a ticket, going to court for riding a bicycle. I mean, come on, take

a whole day out of your whole day, lose a paycheck because you rode a bike over your thing, and it's just not right. But I mean, I hope Mamdani, you know what I mean, he makes the right decision going forward to fire the Commissioner.

SERGEANT-AT-ARMS: Time expired.

CHRISTOPHER LEON JOHNSON: Make you the Commissioner, Tiffany Cabán. All right. So, thank you, enjoy your day.

CHAIRPERSON CABÁN: Thank you.

And next we have Peggy Herrera.

SERGEANT-AT-ARMS: You may begin.

CHAIRPERSON CABÁN: Okay. I think she's no longer with us on the Zoom.

So, with that, thank you to everyone who has testified. If there's anyone present in the room or on Zoom that hasn't had the opportunity to testify, please raise your hand.

Seeing no one else, I'd like to note that written testimony, which will be reviewed in full by Committee Staff may be submitted to the record up to 72 hours after the close of this hearing by emailing it to testimony@council.nyc.gov. Thank you. [GAVEL]

C E R T I F I C A T E

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

Date April 28, 2026